91-1578

Supreme Court, U.S.
FILED
MAR 27 1992
OFFICE OF THE CLERK

No.

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

JANE TOMCZYK,

Petitioner,

v.

BLUE CROSS AND BLUE SHIELD UNITED OF WISCONSIN,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

MARJAN R. KMIEC
Counsel of Record
KMIEC LAW OFFICES
3741 West National Avenue
Milwaukee, Wisconsin 53215
(414) 649-9790
Attorneys for Petitioner

Midwest Law Printing Co., Chicago 60611, (312) 321-0220

QUESTIONS PRESENTED

1. May the courts grant and affirm summary judgment as a matter of law when the affidavits are in conflict and raise genuine issues of fact and shift the burden of proof to the non-moving party.

2. Does ERISA provide a distinction between insured and self-insured employee benefit plans and may a state regulate the insurer and its insurance contracts, particularly if the state law applies only to the insurance business.

TABLE OF CONTENTS

	PAGE
QUESTIONS PRESENTED	i
TABLE OF CONTENTS	ii
INDEX TO APPENDIX	iii
TABLE OF AUTHORITIES	iv
OPINIONS BELOW	2
JURISDICTION	2
STATUTES INVOLVED	2
STATEMENT OF THE CASE	4
REASONS FOR GRANTING THE WRIT	9
A. SUMMARY JUDGMENT DISPOSITION OF ERISA CLAIM WAS IMPROPER	9
B. THE DISMISSAL OF STATE LAW REMEDIES THAT PURPORT TO REGULATE THE INSURER HEREIN	11
C. CASTIGATION OF TOMCZYK COUNSEL AND IMPOSITION OF SANCTIONS	17
LIMITED RESPONSE AND CONCLUSION	20

INDEX TO APPENDIX

	APP. PAGE
Opinion of the United States Court of Appeals for the Seventh Circuit, December 30, 1991 ...	1
Judgment of the United States Court of Appeals for the Seventh Circuit, December 30, 1991 ..	17
Decision and Order of the United States District Court, Eastern District of Wisconsin, December 6, 1990	18
Decision and Order of the United States District Court, Eastern District of Wisconsin, May 8, 1989	30
Pertinent Pages of Appellant's Brief in the United States Court of Appeal for the Seventh Circuit ..	39
Pertinent Pages of the Appellant's Reply Brief in the United States Court of Appeal for the Seventh Circuit	41
Affidavit of John A. Goeckerman, D.D.S.	44
Explanation of Benefits by Blue Cross	48
Affidavit of Elise McKinch, R.N., B.S.	49
"Federal court penalizes law firm $2,000 for frivolous appeal", The Milwaukee Sentinel, January 3, 1992	51

TABLE OF AUTHORITIES

Cases	PAGE
Anderson v. Continental Ins. Co., 271 N.W.2d 368, 85 Wis. 2d 675 (1978)	7, 11, 12, 13
Benke v. Mukwonago-Vernon Mut'l Ins. Co., 329 N.W.2d 243, 110 Wis. 2d 356 (1982)	13
Cedar Rapids Pediatric Clinic Pension Plan v. Continental Ins. Co., 690 F. Supp. 792 (W.D. Ark. 1988)	21
Davis v. Allstate, 303 N.W.2d 596, 101 Wis. 2d 1 (1981)	13
Dvorak v. Pluswood, Wis. Ins., 358 N.W.2d 544, 121 Wis. 2d 218 (1984)	13
FMC Corp. v. Holliday, 111 S.Ct. 403 (1990)	14
Gruenberg v. Aetna Ins. Co., 9 Cal. 3d 566, 108 Cal. Rptr. 480, 510 P.2d 1032 (1973)	13
Hilker v. Western Auto. Ins. Co., 235 N.W. 413, 204 Wis. 1 (1931)	12, 13
Indianapolis Colts v. Mayor of Baltimore, 775 F.2d 177 (7th Cir. 1985)	19
Kranzush v. Badger State Mut'l Cas. Co., 307 N.W.2d 256, 103 Wis. 2d 56 (1981)	13
Maciosek v. Blue Cross and Blue Shield United of Wisconsin, 930 F.2d 536 (7th Cir. 1991)	18
Mays v. Chicago Sun Times, 865 F.2d 134 (7th Cir. 1989)	19
Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 105 S.Ct. 2380 (1985)	15, 16
Moutoux v. Gulling Auto Elec., Inc., 295 F.2d 573 (7th Cir. 1971)	9

Pilot Life v. Dedeaux, 481 U.S. 41 (1987) 7, 11, 20, 21

Poling v. WPS, 357 N.W.2d 293, 120 Wis. 2d 603 (1984) 13

Reilly v. Blue Cross and Blue Shield United of Wisconsin, 846 F.2d 416 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988) 16

Smith v. Blue Cross & Blue Shield United of Wisconsin, 724 F. Supp. 618 (E.D. Wis. 1989) ... 21

Tomczyk v. Blue Cross and Blue Shield United of Wisconsin, Case No.: 91-1018 (7th Cir.) 2

Statutes

28 U.S.C. Sec. 1291 4

28 U.S.C. Sec. 2101(c) 2

29 U.S.C. Sec. 1132 4

29 U.S.C. Sec. 1132(a)(3) 2

29 U.S.C. Sec. 1144(a) 3

29 U.S.C. Sec. 1144(a)(3) 3

29 U.S.C. Sec. 1144(b)(2)(A) 3

29 U.S.C. Sec. 1144(b)(2)(B) 3

Fed. R. Civ. P. 56(c) 9

Other

Wis. JI-Civil 2760 14

Wis. JI-Civil 2761 14

Wis. JI-Civil 2762 14

IN THE

Supreme Court of the United States

OCTOBER TERM, 1991

JANE TOMCZYK,

Petitioner,

v.

BLUE CROSS AND BLUE SHIELD
UNITED OF WISCONSIN,

Respondent.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

Petitioner, Jane Tomczyk, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Seventh Circuit affirming the District Court for the Eastern District of Wisconsin granting of summary judgment to Blue Cross on ERISA claims and dismissing all other claims dealing with state law regulation of an insurance company, insuring an employee benefit plan.

OPINIONS BELOW

The judgment in *Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*,[1] Case No.: 91-1018 (7th Cir.) was decided and entered on December 30, 1991.

The decisions and orders of the United States District Court for the Eastern District of Wisconsin dated May 8, 1989 and December 6, 1990.

JURISDICTION

The United States Supreme Court has jurisdiction to review the judgment in question hereby by writ of certiorari pursuant to 28 U.S.C. Sec. 2101(c).

STATUTES INVOLVED

This case involved the following statutory provisions: Sec. 514(a), 29 U.S.C. Sec. 1144(a); Sec. 514(b)(2)(A), 29 U.S.C. Sec. 1144(b)(2)(A); Sec. 502(a)(3), 29 U.S.C. Sec. 1144(a)(3); and 29 U.S.C. Sec. 1132(a)(3).

---

[1] *Jane Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*, United States Court of Appeals for the Seventh Circuit, Case No. 91-1018, by the Honorable Richard A. Posner, the Honorable Joel M. Flaum and the Honorable Michael S. Kanne. Per Curiam.

Sec. 514(a), 29 U.S.C. Sec. 1144(a) (pre-emption clause) states in pertinent part:

> "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan . . . ."

Sec. 514(b)(2)(A), 29 U.S.C. Sec. 1144(b)(2)(A) (savings clause) states:

> "Except as provided in subparagraph (B) [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."

Sec. 514(b)(2)(B), 29 U.S.C. Sec. 1144(b)(2)(B) (deemer clause) states:

> "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies."

Lastly, Sec. 502(a)(3), 29 U.S.C. Sec. 1144(a)(3) provides:

> "A civil action may be brought:
>
> (3) By a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan or (B) to obtain other appropriate relief (i) to redress such violations or (ii) to enforce any provisions of the subchapter or terms of the plan;"

STATEMENT OF THE CASE

This case was originally filed on June 29, 1988 in the United States District Court for the Eastern District of Wisconsin, Case Number 88-C-690. The District Court had original jurisdiction in this matter pursuant to 29 U.S.C. Sec. 1132 and also had jurisdiction over pendent state laws that regulate the business of insurance.

On May 8, 1989, the District Court, by the Honorable Robert W. Warren, by order granted the defendant-appellee's motion for summary judgment dismissing Jane Tomczyk's state law claims. (App. 30). The court requested supplemental briefs on summary judgment in regards to Jane Tomczyk's claim for ERISA benefits.

On December 6, 1990, the District Court dismissed the plaintiff's remaining ERISA claims for benefits. (App. 18).

Jane Tomczyk appealed the judgments of May 8, 1989 and December 6, 1990 to the United States Court of Appeals for the Seventh Circuit pursuant to 28 U.S.C. Sec. 1291.

The Appellate Court issued its Per Curiam decision and judgment on December 30, 1991 and it was received by Kmiec Law Offices on January 2, 1992. (App. 1 and 17). The Court of Appeals affirmed the District Court in all respects and imposed Rule 38 sanctions on the appellant's attorneys, Marjan R. Kmiec and Christopher A. McConville of Kmiec Law Offices, ". . . because of the largely frivolous nature of this appeal, as well as the misleading manner in which it was presented to this Court, ..." (App. 1).

The Court of Appeals found that there were no genuine issues as to any material facts and entered summary judgment as a matter of law based on the affidavits and the defendant's motion for summary judgment.

The Appellate Court, in its opinion, disagreed with Tomczyk that her affidavit by Dr. Goeckerman raised an issue of fact regarding pre-authorization of her hospital and medical bills by Blue Cross. The court did accept the affidavit of McKinch, R.N., employee of Blue Cross, to the effect that Blue Cross "would authorize a three (3) day inpatient hospital stay" as merely an indication that "the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage."

Attorney McConville was categorized by the Court as falsely asserting that Dr. Goeckerman "thought he had authority not only for the hospital stay, but for the surgery" on the basis that Dr. Goeckerman sent a letter to Blue Cross on October 7, 1987—four (4) days after the surgery—with the first sentence reading "this letter is sent as a request for prior determination of benefits."

The Court stated that the doctor's letter shows he knew Blue Cross had not pre-authorized the surgery that had already taken place on October 3, 1987.

The Court concluded as a matter of law that Attorney McConville had manipulated facts and found that no material facts existed as to whether the surgical treatment was, in fact, authorized.

The Court also concluded that although there was no dispute that the hospital stay was pre-authorized, it does not necessarily result in reimbursement. The pre-authorization somehow only related to the need to have the pro-

cedure done as an inpatient but did not, in fact, authorize coverage.

The Court of Appeals further admonished Attorney McConville to the effect that he perpetuated these blatantly inaccurate characterizations at oral argument. The Court was referring to Attorney McConville's oral argument in reference to the affidavits and the letter of Dr. Goeckerman. The Court remarked that Attorney McConville's oral argument in said respect, "highlight his generally distressing approach in this appeal." (App. 5).

The Court concluded that the plaintiff must set forth specific facts showing a genuine issue of material fact which requires trial, which the plaintiff had not done.

The District Court on the motion for summary judgment had bifurcated the causes of action dealing with state court remedies and ERISA benefits. The District Court judgment dismissing the cause of action in respect to state law regulations was filed on May 8, 1989 and the Court then granted its summary judgment in respect to ERISA benefits on December 6, 1990. (App. 30 and 18).

The Court of Appeals in its decision subsequent to affirming the summary judgment on the merits of the case dealing with ERISA benefits continued in its decision to review the summary judgment in respect to state court remedies.

The Court of Appeals found that Tomczyk was attempting to circumvent ERISA's broad pre-emption through the use of the savings clause and tried to salvage the breach of contract and related state law claims as federal law claims based on a breach of fiduciary duty under ERISA. (App. 7).

The Court found that the parties do not dispute the fact that the plan is, in fact, insured.

The Court further concluded that Tomczyk, in trying to distinguish Mississippi punitive damage law in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) and Wisconsin bad faith law application to insurance regulation had attempted to mislead the Court of Appeals, which was commonplace in this appeal. That Tomczyk ignores the clear mandate of Supreme Court precedent. (App. 7-8).

The Court used Tomczyk's citation of *Anderson v. Continental Ins. Co.*, 85 Wis. 2d 675, 271 N.W.2d 368 (1978), to the effect that indeed *Anderson* not only did not limit bad faith law to the insurance industry, but stated to the contrary that "every contract imposes upon each party a duty of good faith and fair dealing in its performance and enforcement." *Anderson* at 375.

The Court felt that Tomczyk's reliance upon *Anderson* was an attempt to mislead the Court of Appeals.

The Court stated that Tomczyk was attempting to add a new twist in asking the court to consider state common law claims as claims for breach of fiduciary duty under ERISA and that it was an "ostrich like" attempt by Tomczyk's counsel to avoid existing authority in an unprofessional and pointless manner. (App. 10).

The Court of Appeals concluded that Tomczyk's counsel, Christopher A. McConville and Marjan R. Kmiec, both of Kmiec Law Offices, continued a disturbing pattern of litigating claims that repeatedly advanced the same frivolous arguments. (App. 10).

The Court stated that an appeal is frivolous when the result is obvious or when the appellant's argument is wholly without merit. (App. 14). The Court concluded that

there were no colorable basis in law for the litigant's position.

The Court then concluded that Tomczyk ignored, glossed over or misstated the law. That puffery was proffered as fact and that the attorneys presented the record in a thoroughly misleading and unprofessional fashion, thereby demonstrating frivolousness. The entire manner in which this appeal had been pursued justified sanctions. (App. 15). The Court then imposed a significant penalty against Tomczyk's attorneys in the amount of $2,000.00 and further assessed the costs of the appeal upon counsel in the amount of $688.94.

The plaintiff, Jane Tomczyk, and her counsel, Marjan R. Kmiec, petition this court for a writ of certiorari regarding the summary judgment dismissal of the ERISA claims, the dismissal of state laws that regulate insurers and insurance contracts, the imposition of sanctions and costs of appeal and the castigation of Tomczyk's counsel with the hopeful restitution of their reputation.

REASONS FOR GRANTING THE WRIT

A.

SUMMARY JUDGEMENT DISPOSITION OF ERISA CLAIM WAS IMPROPER.

Christopher McConville, the attorney who briefed this case and appeared at the oral argument before the Court of Appeals, is no longer with Kmiec Law Offices. The petitioner's counsel herein, Marjan R. Kmiec, hastily points out that he has respect for the integrity and honesty of Attorney McConville, particularly in his judicial representations.

It is incumbent upon the moving party to show that there are no material facts in dispute and if there is any doubt concerning the existence or non-existence of a material fact, that doubt or reasonable inference must be resolved against the moving party and summary judgment will not be granted. Fed. R. Civ. P. 56(c). *Moutoux v. Gulling Auto Elec., Inc.*, 295 F.2d 573, 577 (7th Cir. 1971).

It is Tomczyk's position that the Court of Appeals in affirming the District Court's summary judgment order violated the legal standards for deciding summary judgment motions as set out in Fed. R. Civ. P. 56(c) and decisions of the Seventh Circuit Court of Appeals. The Court (at App. 5) indicated it was disturbed by the manner in which counsel for Tomczyk manipulated relevant facts.

The fact is that the record shows unequivocally that the purpose for contacting Blue Cross on September 30, 1987 was to obtain the pre-authorization for the plaintiff's surgery and that a representative of Blue Cross stated that the plaintiff's insurance had authorized the hospital stay *for the intended surgery*. (App. 44).

The Court of Appeals stated that McConville had falsely asserted to the court that Goeckerman thought he had authority for the hospital stay and the surgery, particularly because the October 7, 1987 letter was a request for prior determination of benefits in respect to surgery that had already been performed on October 3, 1987.

The fact is that the surgery had not been performed on October 3, 1987, but rather was performed on October 21, 1987 and October 27, 1987. (App. 48).

The Court of Appeals refers to the affidavit of Dr. Goeckerman only in the context that the hospital stay was pre-authorized but the court would not infer that the hospital stay and surgery were pre-authorized in spite of Dr. Goeckerman's affidavit that the purpose of the contact with Blue Cross was to obtain pre-authorization of the plaintiff's surgery and that ". . . Blue Cross stated that the plaintiff's insurance had authorized the hospital stay for the intended surgery." (App. 44).

The Court made no reference to paragraph four (4) of Dr. Goeckerman's affidavit to the effect that on June 8 or June 9, 1988 he had received a telephone call from a representative of Blue Cross indicating that it was not specifically stated in the policy that it was not a covered benefit but that Blue Cross simply would not pay the claim. (App. 45).

While Blue Cross does not dispute that they had authorized a hospital stay for the intended surgery, the Court of Appeals found that the authorization for the inpatient hospital stay was simply an indication that the procedure needed to be done as an inpatient but with no authority for coverage.

It is incongruous that Blue Cross would have a pre-authorization procedure that would authorize a three (3)

day inpatient hospital stay for surgery that it would not authorize.

In conclusion, the affidavits submitted on summary judgment regarding the ERISA claim itself can be interpreted as the reader chooses. Tomczyk submits that the legal standards for deciding summary judgment motions were not applied and, if anything, doubt or reasonable inferences were resolved against the non-moving party, contrary to law. A trial by affidavit is unfair and adds but another burden to recoveries under ERISA.

B.

THE DISMISSAL OF STATE LAW REMEDIES THAT PURPORT TO REGULATE THE INSURER HEREIN.

Blue Cross is an insurance company. The employee benefit plan herein is insured. This is conceded by both parties and the Court of Appeals. The employer is not a party to the action and the action involves only the insurer.

It is suggested that the Court of Appeals may have declined to proceed any further with this case following the dismissal of the case on the merits in respect to the ERISA claim. The court did, however, continue with the resulting imposition of sanctions against Tomczyk's counsel.

Tomczyk attempted to distinguish Mississippi bad faith law cited in *Pilot Life v. Dedeaux*, 481 U.S. 41 (1987) with Wisconsin bad faith law which applies only to the insurance industry. The Court of Appeals took issue with Tomczyk's contention by stating that the case of *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368, 85 Wis. 2d 675 (1978) indeed stated to the contrary—that "every *contract* imposes upon each party a duty of good faith and fair

dealing in its performance and its enforcement." *Anderson*, 271 N.W.2d at 375, 85 Wis. 2d at 689. (Quoting, Restatement, Law of Contracts, sec. 231, 2d, (1973). (Emphasis added).

In due deference to the Court of Appeals, the Court's citation of a partial sentence from *Anderson* to the effect that Wisconsin bad faith law has general application to contracts is totally misplaced and undermines the Court of Appeal's decision.

It is an abuse of Tomczyk's counsel for the Court to conclude that attempts such as this to mislead the Court were unfortunately a commonplace in this appeal. (App. 8).

Tomczyk's counsel has been involved in a number of Wisconsin state court bad faith lawsuits. Counsel does not attempt to deceive or mislead any court with its position that the common law concept of bad faith has been applied in Wisconsin only in cases involving the insurance industry and insurance contracts.

Anderson is a bad faith insurance case. *Anderson*, after stating that bad faith is not a tortious breach of contract but a separate intentional wrong resulting from a breach of duty, imposed as a consequence of the relationship established by contract, 271 N.W.2d at 374, 85 Wis. 2d at 687, adds at the following page that "this duty is implied as a correlative duty growing out of certain rights and privileges which the contract confers upon the insurer." *Anderson*, 271 N.W.2d at 375, quoting, *Hilker v. Western Auto. Ins. Co.*, 235 N.W. 413, 414, 204 Wis. 1, 13 (1931).

The *Anderson* court predicates its bad faith rationale upon *Hilker v. Western Automobile Ins. Co.*, 231 N.W. 257, 235 N.W. 413, 204 Wis. 1 (1930, 1931). The court in *Hilker* found that Hilker's rights could not be predicated

on any policy provision, but that all courts agreed that the insurer owes to the insured, some duty in this respect.

Anderson cited the California case of *Gruenberg v. Aetna Ins. Co.*, 9 Cal. 3d 566, 108 Cal. Rptr. 480, 510 P.2d 1032 (1973) to the effect that "it is manifest that a common legal principal underlies all of the foregoing decisions; namely, that in every insurance contract there is an implied covenant of good faith and fair dealing . . . accordingly, when the insurer unreasonably and in bad faith withholds payment of the claim of its insured, it is subject to liability in tort." *Anderson*, 271 N.W.2d at 375.

The Wisconsin court stated *Gruenberg* applied the principal of law set forth by the Wisconsin court in *Hilker* in 1930. *Anderson*, 271 N.W.2d at 376. The Wisconsin court accepted the bad faith principles of *Gruenberg* "to be applicable to first party claims which may be asserted in Wisconsin against insurance companies." *Anderson*, 271 N.W.2d at 376.

The Wisconsin Supreme Court and Appellate Courts have applied bad faith principles to insurance contracts in all of the following cases: *Davis v. Allstate*, 303 N.W.2d 596, 101 Wis. 2d 1 (1981); *Kranzush v. Badger State Mut'l Cas. Co.*, 307 N.W.2d 256, 103 Wis. 2d 56 (1981); *Benke v. Mukwonago-Vernon Mut'l Ins. Co.*, 329 N.W.2d 243, 110 Wis. 2d 356 (1982); *Poling v. WPS*, 357 N.W.2d 293, 120 Wis. 2d 603 (1984) and *Dvorak v. Pluswood, Wis. Ins.*, 358 N.W.2d 544, 121 Wis. 2d 218, 220 (1984), to the effect that "*Anderson* did recognize a separate tort action for bad faith breach of an *insurance* contract. . . ." 358 N.W.2d at 546, 121 Wis. 2d 218. (emphasis added).

Dvorak also held that a breach of an implied public policy provision in an employment contract creates a con-

tract action and not a tort action. 358 N.W.2d at 546, 121 Wis. 2d at 220.

Finally, Wisconsin Jury Instructions 2760, 2761 and 2762, are the only Wisconsin Jury Instructions that deal with bad faith and their exclusive application relates to the insurance industry and insurance contracts.

The Supreme Court has made its most definitive pronouncement in respect to the distinction between insured and uninsured plans in the context of state regulation of insurers and insurance contracts in the case of *FMC Corp. v. Holliday*, 111 S.Ct. 403 (1990). The Court set forth meticulously the various provisions of ERISA, 29 U.S.C. Sec. 1144(a), dealing with pre-emption, the savings clause and the deemer clause. *FMC*, at 407. This writer has adopted said citations and sets them forth in this petition under the title "STATUTES INVOLVED".

Significantly, the Supreme Court stated that said provisions are not a model of legislation. *FMC*, at 407.

The court in *FMC* found that a Pennsylvania anti-subrogation law was excluded from the reach of the savings clause because the deemer clause does not exempt self-funded ERISA plans from state laws that regulate insurance within the meaning of the savings clause. *FMC*, at 409. The court concluded that self-funded employee benefit plans are exempt from state regulations in so far as that regulation "relates to" the plans. *FMC*, at 409.

Importantly, the Supreme Court stated that on the other hand, employee benefit plans that are insured are subject to indirect state insurance regulations. An insurance company that insures a plan remains an insurance company for purposes of state laws purporting to regulate insurance. *FMC*, at 409.

It is obvious that even after application of the deemer clause, an insurance company remains an insurance company and is subject to state laws. Insurance companies obviously do not fall under some sort of protective mantel of an ERISA limitation of remedies. Rather it is employee benefit plans which ERISA controls.

The court made reference to its decision in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380 (1985) indicating that state statutes as applied to insurers of the plan were not pre-empted because they regulated insurance and were, therefore, saved. The Supreme Court acknowledged that their decision resulted in a "distinction between insured and uninsured plans, leaving (insured) plans open to indirect regulation and (uninsured) plans not." *Metropolitan*, 471 U.S. at 747. The *FMC* court further stated that Congress did not intend to pre-empt areas of traditional state regulation and there was a recognized distinction between insurers of plans and the contracts of those insurers which are subject to direct state regulation and self-insured employee benefit plans governed by ERISA, which are not. The court concluded that it observed Congress' presumed desire to reserve to the states the regulation of the "business of insurance." 111 S.Ct. at 410.

The court emphasized that the savings clause protects state regulation of insurance contracts purchased by employee benefit plans. *FMC*, 111 S.Ct. at 411.

The key conclusion of the court was "our interpretation of the deemer clause makes clear that if a plan is insured, a state may regulate it *indirectly* through *regulation of its insurer* and its insurer's insurance contracts; if the plan is uninsured the state may not regulate it." *FMC*, 111 S.Ct. at 411.

Justice Stevens in his dissent would go further. He felt the pre-emption clause was read to broadly by the majority and should apply only to state laws that purport to regulate subjects regulated by ERISA that are inconsistent with ERISA's central purpose.

It is interesting to note that the Tomczyk court made a footnote reference only to *Reilly v. Blue Cross and Blue Shield United of Wisconsin*, 846 F.2d 416, 418 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988), for the proposition that the court had therein definitively held that punitive damages are not available under ERISA. Circuit Judge Posner was a member of the *Reilly* court and is, of course, a member of the Tomczyk court. Judge Posner dissented with the majority in *Reilly*.

The majority in *Reilly* found that if a plan purchases insurance, as opposed to being self-insured, it is "directly affected by state laws that regulate the insurance industry." *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985). The *Reilly* court concluded that "we need not decide whether Wisconsin law concerning punitive damages and bad faith regulates insurance." 846 F.2d at 425. The reason being that the court found the plan in *Reilly* was self-insured. *Id.* The *Reilly* decision has never been overturned.

Judge Posner, in his *Reilly* dissent, indicated that "the denial of benefits may be right or wrong but it is a reasonable interpretation of the plan, and that should be the end of the case." 846 F.2d at 427. Judge Posner found that Judge Will, who wrote the majority opinion, disregarded the court's role in the proceeding, the nature of the proceeding, the standard of review and the burden of proof, but he has gone beyond the issues framed by the parties. *Id.*

C.

CASTIGATION OF TOMCZYK COUNSEL AND IMPOSITION OF SANCTIONS.

The court states that Attorney McConville's contention that Dr. Goeckerman thought he had authority not only for the hospital stay but for the surgery was a false contention by McConville because Dr. Goeckerman was indeed aware that Blue Cross had not pre-authorized the surgery in a letter dated October 7, 1987 in that he had already performed the surgery on October 3, 1987. The fact is that the surgery was not performed on October 3, 1987 as indicated in the court's decision, but rather on October 21, 1987 and October 27, 1987. (App. 48).

The Court went on to indicate that it was disturbed by the manner in which counsel for Tomczyk manipulated relevant facts.

That Tomczyk's brief reads into Goeckerman's affidavit statement that simply are not there. That Tomczyk's brief misrepresents the context of Dr. Goeckerman's letter of October 7, 1987. (App. 46-47). That Tomczyk's attorney perpetuated these blatantly inaccurate characterizations at oral argument and that only served to highlight his generally distressing approach in this appeal.

The court states that Tomczyk ignored the clear mandate of Supreme Court precedent, misstates the holdings of cases she cited in support of her position and fails to cite relevant cases from within this circuit.

The court stated that counsel's attempts to distinguish Mississippi bad faith law from that of Wisconsin was an attempt to mislead this court which were unfortunately and commonplace in this appeal. (App. 8).

The court claims that counsel failed to cite district court opinions in respect to cases that were pending on appeal and that it gave short shrift to the *Maciosek v. Blue Cross and Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991).

The Court categorizes counsel's arguments as once more relying on the savings clause where this court previously rejected the attempt to circumvent the clear pre-emptive mandate of ERISA.

The Court accused counsel of adding twists in asking this court to consider state common law claims as claims for breach of fiduciary duty under ERISA. The court categorized Tomczyk's ostrich like attempts as being unprofessional and pointless.

The Court rejected Tomczyk's efforts to bootstrap state common law claims onto the ERISA claim. The court indicated that all said claims were pre-empted by ERISA.

The Court stated that counsel had refused to acknowledge the unfavorable holding in *Maciosek* until they were forced to address *Maciosek* following its prominent mention by Blue Cross.

The Court indicated that counsel employed a tactic of ignoring existing and potentially dispositive precedent as well as making numerous attempts to mislead this court through bold misrepresentations of fact and law and that it was a disservice to the parties, opposing counsel and this court.

Before leveling sanctions, the Court indicated that it wished to make clear that it was not its intent to "chill" discussion or to dissuade counsel from bringing credible appeals. The Court did not want to make itself a variable "mine field" for litigants as they determine whether to

pursue appeals. The Court indicated it only wanted a honest presentation of the case, adherence to the basic technical rules and a colorable basis in law and fact—as well as a certain amount of common sense and attorneys will thereby be shielded from sanctions.

The Court then cited that "an appeal is frivolous when the result is obvious or when the appellant's argument is wholly without merit." *Mays v. Chicago Sun Times*, 865 F.2d 134, 138 (7th Cir. 1989) (quoting, *Indianapolis Colts v. Mayor of Baltimore*, 775 F.2d 177, 184 (7th Cir. 1985)).

The Court continued with this tenure of comment about Tomczyk counsel for the balance of the decision.

The decision and comments of the Court in castigating Tomczyk counsel was prominently reported in the Milwaukee Journal, which has a state wide distribution. (App. 51). The Wisconsin Board of Attorney Professional Responsibility is currently investigating Attorneys Kmiec and McConville because of the sanctions imposed by the Tomczyk court.

LIMITED RESPONSE AND CONCLUSION

Tomczyk and her counsel implore the Supreme Court to allow it to fully address the summary judgment disposition of Tomczyk as a matter of law by the Court of Appeals and the District Court. Tomczyk believes its ERISA claims were tried on affidavits and is error as a matter of law.

We ask the court to allow Tomczyk to address the complexity of ERISA's pre-emption, savings and deemer clauses, particularly as to their early development and subsequent use by insurance companies as a defense to suits involving allegations of state court remedies.

We would like to address the ongoing dynamics of ERISA remedies. In this context, the Supreme Court indicated that "it is also intended that a body of federal substantive law be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Pilot Life*, 481 U.S. at 56.

The Supreme Court expected that a federal common law of rights and obligations under ERISA would develop to regulate plans and remedies. Tomczyk's counsel suggested to the Court of Appeals, Seventh Circuit, that state laws could be utilized in the development of federal common law in ERISA claims. The court condemned that effort as bootstrapping by Tomczyk's counsel of state laws into federal common law. (App. 10; App. 41-43).

The court also condemned Tomczyk's attempts to address the fiduciary responsibility of ERISA as adding a twist and an ostrich like attempt by Tomczyk's counsel to avoid existing authority in an unprofessional and pointless manner. (App. 10).

We point out that the Supreme Court indicates that a beneficiary may bring a cause of action for breach of fiduciary duty. *Pilot Life*, 481 U.S. at 53. We submit that matters of fiduciary duties and state common law rights should be at least discussed and potentially incorporated into federal substantive law dealing with issues involving rights and obligations under private welfare and pension plans in an ERISA context. (App. 39-40). *Cedar Rapids Pediatric Clinic Pension Plan v. Continental Ins. Co.*, 690 F. Supp. 792, 795 (W.D. Ark. 1988).

We particularly ask the Supreme Court to allow Tomczyk counsel to show to the court that they had no intention to mislead or to be unprofessional in appealing Tomczyk. We ask the court to allow us to seek restitution of our reputation. We would like to get a good night sleep. The writer, in 32 years, has never seen a decision that reflects the total antipathy shown in Tomczyk by the Court of Appeals on virtually every issue raised by counsel.

Although the Seventh Circuit has provided that its intention was not intended to chill counsel from bringing actions, this counsel has been thoroughly intimidated and is concerned about the potential repercussions for filing this petition.

We ask the court to allow us to show to the court that Rule 38 sanctions are misplaced in this case.

We are particularly concerned in that *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 724 F. Supp. 618 (E.D. Wis. 1989) is still pending before the Court of Appeals, although oral argument took place on February 14, 1991. Many of the issues in *Smith* are similar to Tomczyk.

We understand the Supreme Court has the authority to summarily decide a case. As an alterative to the court denying the writ, the petitioner would request the court

to exercise its discretion and summarily decide the issues herein. This case, however, raises issues of concern for all attorneys who practice in the Seventh Circuit and for all citizens with an interest in an insured employee benefit plan. If the Supreme Court does not respond to the issues herein, Tomczyk counsel will be at a loss on how to proceed, if at all, in future ERISA cases. It is doubtful that counsel will accept ERISA related cases in the future regardless of their merits. If this was the intended effect of the Seventh Circuit and of Blue Cross, it is likely that they have accomplished their purpose. We do believe that this case raises important issues and that a Writ of Certiorari should issue.

Respectfully submitted,

MARJAN R. KMIEC
Counsel of Record
KMIEC LAW OFFICES
3741 West National Avenue
Milwaukee, Wisconsin 53215
(414) 649-9790
Attorneys for Petitioner

Dated: March, 1992

APPENDIX

IN THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

No. 91-1018

JANE TOMCZYK,

Plaintiff-Appellant,

v.

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN,

Defendant-Appellee.

Appeal from the United States District Court
for the Eastern District of Wisconsin.
No. 88 C 690—**Robert W. Warren,** *Judge.*

ARGUED OCTOBER 18, 1991—DECIDED DECEMBER 30, 1991

Before POSNER, FLAUM, and KANNE, *Circuit Judges.*

PER CURIAM. Jane Tomczyk brought this action against Blue Cross and Blue Shield United of Wisconsin (Blue Cross), a Wisconsin non-profit corporation, alleging ERISA, state common-law, and constitutional violations. The District Court granted summary judgment to Blue Cross on the ERISA count, and dismissed the others. Tomczyk appeals the disposition of her ERISA and state common-law claims. We affirm. Moreover, because of the largely frivolous nature of this appeal, as well as the misleading manner in which it was presented to this Court, we impose Rule 38 sanctions on Tomczyk's attorneys, Marjan Kmiec and Christopher McConville of Kmiec Law Offices.

I.

Jane Tomczyk is a member of an ERISA-regulated group health insurance plan issued by Blue Cross and sponsored by her employer. After undergoing oral surgery on October 3, 1987, she filed a claim with Blue Cross for reimbursement of approximately $8,250 in surgical and hospital fees. Blue Cross denied the claim. Tomczyk sued Blue Cross under ERISA for denial of benefits, *see* 29 U.S.C. § 1132(a)(1)(B), (a)(3), brought state common-law claims of bad faith, breach of contract, and tortious interference with her contractual relationship with her doctor, and asserted a constitutional claim under 42 U.S.C. § 1983. She sought reimbursement of her medical costs, as well as extra-contractual compensatory and punitive damages.

The District Court dismissed the state common-law claims as preempted by ERISA, and the § 1983 claim owing to a lack of state action. *See Tomczyk v. Blue Cross & Blue Shield United of Wisconsin*, 715 F. Supp. 914, 918 (E.D. Wis. 1989). In a separate decision granting Blue Cross summary judgment on the ERISA claim, the court determined that no genuine issue of material fact existed and found that Blue Cross had properly denied benefits to Tomczyk under the terms of the contract. *See Tomczyk v. Blue Cross & Blue Shield United of Wisconsin*, No. 88-C-690, slip op. at 13 (E.D. Wis. Dec. 6, 1990). Tomczyk appeals the grant of summary judgment to Blue Cross on the ERISA claim, and the dismissal of her state common law and extra-contractual damage claims. We first examine her ERISA claim.

A.

We review *de novo* the District Court's grant of summary judgment to Blue Cross. *See Doe v. Allied-Signal, Inc.*, 925 F.2d 1007, 1008 (7th Cir. 1991). Summary judgment must be granted if the pleadings and supporting documents "show there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). We must view

the record and all inferences drawn from it in the light most favorable to the nonmoving party. *See Lohorn v. Michal*, 913 F.2d 327, 331 (7th Cir. 1990). The nonmoving party, however, may not rest on its pleadings, and must demonstrate, with specific evidence, that a genuine issue of triable fact remains. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986).

The District Court concluded that the oral surgery performed on Tomczyk was not a covered procedure under her insurance plan. Tomczyk has not appealed the court's *de novo* interpretation of the insurance contract. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989) (courts must review denial of ERISA plan benefits *de novo* unless the plan gives the administrator discretionary authority to determine benefit eligibility or to construe doubtful or contested terms, in which case the arbitrary and capricious standard applies). Rather, Tomczyk claims that the court should not have granted summary judgment because whether Blue Cross authorized her medical expenses is a disputed factual issue. We disagree.

Tomczyk receives her insurance coverage through the Blue Cross "Advantage Program." Under this program, certain requirements must be met before a plan member may receive full benefits for covered services for nonemergency inpatient hospital care. Blue Cross must determine that the hospitalization is medically necessary and authorize the care. Additionally, the member must notify Blue Cross prior to admission that hospitalization is anticipated, and a length of stay must be authorized. The contract provides that, "[i]f the admission was not preauthorized, benefits will be limited to 80% of the amount otherwise allowed according to the contract provisions for covered benefits." Exhibit A, Section MC, at 74. Moreover, the contract states that even where the hospital stay is preauthorized, "[o]ther limitations, exclusions and conditions of the contract are not affected by this section and still apply." *Id.*

Tomczyk first consulted with John Goeckerman, D.D.S., who subsequently performed the surgery on her jaw, on September 21, 1987. Dr. Goeckerman determined that Tomczyk required corrective treatment consisting of two variations of a surgical procedure known as "osteotomy of the temporo mandibular joint." On September 30, an employee with Dr. Goeckerman's office called Blue Cross's Advantage Program and spoke to Elise McKinch, R.N., a "Managed Care Specialist" who reviews inpatient hospital admissions and authorizes lengths of stay. Tomczyk contends that Blue Cross authorized her October 3 surgery in that telephone conversation.

In her brief, Tomczyk claims that McKinch told Dr. Goeckerman's office that her "insurance was in 'perfect standing' " and that Blue Cross "would cover all medical costs regarding Jane Tomczyk's medically necessary surgery, thereby approving said surgical treatments." Appellant's Br. at 5-6. Nowhere does the record support such an assertion. The sole piece of evidence Tomczyk cites in this regard is Dr. Goeckerman's affidavit. That affidavit, however, states only that McKinch had told his office that Blue Cross "had authorized the hospital stay for the intended surgery," Goeckerman Affidavit at 1, an assertion Blue Cross does not dispute. According to McKinch's affidavit, she informed Dr. Goeckerman's office that she "would authorize a three day inpatient hospital stay." McKinch Affidavit at 2. Significantly, however, her affidavit also states that she informed Dr. Goeckerman's office "that the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage," *id.*, and "that it would be advisable to get verification of coverage from Blue Cross' Medical Review department." *Id.* Additionally, because she had determined, and informed Dr. Goeckerman's office, that the procedure might not be covered, she did not send the customary letter confirming admission preauthorization. *Id.* Tomczyk presents no evidence disputing McKinch's statements or showing that Blue Cross authorized the surgery or otherwise agreed to pay for the hospital stay.

Tomczyk's brief argues that since Blue Cross authorized the hospital stay, one can draw a reasonable inference that it also preauthorized the surgery. Appellant's Br. at 9. At oral argument before this Court, Tomczyk's counsel, Christopher McConville, contended that it is also reasonable to conclude that once Dr. Goeckerman obtained the preauthorization for the hospital stay, "he thought he had authority not only for the hospital stay, but for the surgery." McConville's contention is belied by an October 7 letter Dr. Goeckerman sent to Blue Cross. The first sentence reads, "This letter is sent as a request for prior determination of benefits." Plaintiff's Exhibit A. The letter goes on to outline his diagnosis, suggested treatment, and surgical fees. The plain language of the letter shows that, contrary to McConville's assertion, Dr. Goeckerman was indeed aware that Blue Cross had not preauthorized the surgery, which had been performed on October 3.

We are disturbed by the manner in which counsel for Tomczyk manipulated relevant facts. Her brief reads into Dr. Goeckerman's affidavit statements that simply aren't there. The affidavit states only that the hospital stay was preauthorized; it does not state, as Tomczyk's brief claims, that "Blue Cross would cover all medical costs regarding Jane Tomczyk's medically necessary surgery, thereby approving said surgical treatments." Tomczyk's brief also misrepresents the contents of Dr. Goeckerman's letter of October 7, asserting, for example, that Dr. Goeckerman included the cost breakdowns "as a common curtesy" [sic], Appellant's Br. at 6, when the letter clearly is a request for determination of benefits. That Tomczyk's attorney further perpetuated these patently inaccurate characterizations at oral argument only serves to highlight his generally distressing approach in this appeal. We affirm the District Court, and find that no material fact exists regarding whether the surgical treatment was authorized.

Tomczyk's brief asserts further that, at the very least, Tomczyk should be able to recover the costs of her hospital stay. That the hospital stay was preauthorized is not in dispute; Blue Cross has admitted as much. *See* Appellee's

Br. at 4; McKinch Affidavit at 2. Admission preauthorization, however, does not necessarily result in reimbursement. As we have noted, McKinch's affidavit states that she told Dr. Goeckerman's office that this preauthorization related only to the need to have that type of procedure performed as an inpatient, and did not constitute an authorization of coverage. Tomczyk has offered no evidence to counter this statement. While we must review the record in the light most favorable to Tomczyk, she must set forth specific facts showing that there is a genuine issue of material fact which requires a trial. *Celotex*, 477 U.S. at 324. This she has not done. Under the contract, other limitations and conditions of the contract apply to the section pertaining to hospital admission authorization. The District Court held that Tomczyk's surgery was not a covered procedure under the contract. Therefore, Tomczyk is not entitled to recover the costs of the surgery or the hospital stay. The District Court's grant of summary judgment to Blue Cross on the ERISA claim is affirmed.

B.

Tomczyk also appeals the District Court's dismissal of her state common-law claims of bad faith, breach of contract, and tortious interference with contract. As to her bad faith claim, she attempts to circumvent ERISA's broad preemptive provisions by claiming that the Wisconsin law of bad faith is a law which "regulates insurance" and, as such, avoids preemption through ERISA's "saving clause." She attempts to salvage her claims of breach of contract and tortious interference with contract by recharacterizing them as "federal law claims" and urging this Court to therefore consider them as claims for breach of fiduciary duty under ERISA. Appellant's Br. at 19. We reject her arguments.

1.

Tomczyk contends that the Wisconsin law of bad faith escapes ERISA's broad preemptive scope because it is

a law regulating insurance and thus falls within the ambit of ERISA's "saving clause." *See* 29 U.S.C. § 1144(b)(2)(a). ERISA generally preempts any state law which "relates to" employee benefit plans. *Id.* § 1144(a).[1] The saving clause, however, provides that a state law which specifically "regulates insurance" escapes this preemption, *id.* § 1144(b)(2)(A); *see Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45 (1987), unless the plan at issue is self-insured. *Pilot Life*, 481 U.S. at 45; *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 747 (1985).[2] Tomczyk maintains that, because her health plan is insured—a fact the parties do not dispute—and because Wisconsin bad faith law regulates insurance, her bad faith claim falls within the saving clause. In so asserting, Tomczyk ignores the clear mandate of Supreme Court precedent, misstates the holdings of cases she cites in support of her position, and fails to cite

---

[1] The "preemption clause" states:

> Except as provided in subsection (b) of this section [the "saving clause"], the provisions of this subchapter and subchapter III of this chapter shall supercede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.

29 U.S.C. § 1144(a).

[2] The "saving clause" provides:

> Except as provided in subparagraph (B) [the "deemer clause"], nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

29 U.S.C. § 1144(b)(2)(A). The "deemer clause" states:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, . . . or to be engaged in the business of insurance . . . for the purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

Id. § 1144 (b)(2)(B).

relevant cases from within this Circuit rejecting essentially the same argument—cases, we note, in which Kmiec Law Offices acted as counsel.

In *Pilot Life*—which involved, as here, an insured employee benefit plan—the Supreme Court held that Mississippi bad faith law was not a law regulating insurance within the meaning of § 1144(b). The Court relied primarily on three rationales: the law was not "specifically directed toward the [insurance] industry," 481 U.S. at 50; it did not regulate the transaction of the "business of insurance" under the McCarran-Ferguson Act (*i.e.*, it did not transfer or spread policyholder risk, was not an integral part of the policy relationship between the insurer and insured, and was not limited to entities within the insurance industry), *id.* at 48-49; and allowing the law to escape preemption would violate congressional intent regarding the exclusivity of ERISA's civil enforcement scheme. *Id.* at 57.

Tomczyk attempts to distinguish *Pilot Life* by asserting that, unlike the Mississippi law of bad faith, Wisconsin bad faith law "is directly meant to regulate unfair trade practices within the insurance industry." Appellant's Br. at 15. She cites two cases as authority, *Brockmeyer v. Dun & Bradstreet*, 335 N.W.2d 834 (Wis. 1983), and *Anderson v. Continental Ins. Co.*, 271 N.W.2d 368 (Wis. 1978), neither of which stand for this proposition. *Brockmeyer* did not even address insurance issues; the court merely "refuse[d] to impose a duty to terminate in good faith into employment contracts." 335 N.W.2d at 838. And, although *Anderson* involved insurance, the court did not hold that Wisconsin bad faith law was limited to the insurance industry; indeed, it stated the contrary—that "every contract imposes upon each party a duty of good faith and fair dealing in its performance and its enforcement." 271 N.W.2d at 375.

Attempts such as this to mislead this Court were, unfortunately, commonplace in this appeal. Tomczyk continually ignored relevant precedent from this jurisdiction. Her brief failed to cite a case from the Eastern District of

Wisconsin which specifically held that ERISA preempted the Wisconsin tort of bad faith. *See Rust v. Blue Cross & Blue Shield United of Wisconsin*, No. 87-C-0751, 1988 U.S. Dist. *Lexis* 17207 at *11-12 (E.D. Wis. Sept. 21, 1988). Tomczyk's counsel, McConville and Marjan Kmiec, cannot even attempt to claim ignorance as an excuse: they were counsel in *Rust*. We note, too, that the *Rust* opinion cited *Anderson* to support its finding that Wisconsin bad faith law is *not* limited to the insurance context. *Id.* at *11. Tomczyk also failed to cite *Meyer v. Employers Health Ins. Co.*, 722 F. Supp. 547, 552-53 (E.D. Wis. 1989)—yet another case in which McConville was counsel—in which the plaintiff had relied unsuccessfully on the saving clause as a shield against ERISA preemption of common-law claims of breach of contract, tortious interference with a contractual relationship, and intentional infliction of emotional distress.

Finally, Tomczyk's brief gave short shrift to *Maciosek v. Blue Cross & Blue Shield United of Wisconsin*, 930 F.2d 536 (7th Cir. 1991). In *Maciosek*, this Court held that state common-law claims of breach of contract, tortious interference with a contractual relationship, and violation of a Wisconsin common law which prohibits an insurer from recovering payments absent a mistake of fact, were all preempted by ERISA. The *Maciosek* plaintiffs—again represented by McConville and Kmiec—once more relied on the saving clause, this time with regard to the common-law mistake of fact claim. This Court rejected the attempt to circumvent "the clear preemptive mandate of ERISA." *Id.* at 540. We likewise reject Tomczyk's attempt to escape ERISA's "clear preemptive mandate," as well as to avoid dispositive authority. The District Court's dismissal of the bad faith claim is affirmed.

2.

In appealing her claims for breach of contract and tortious interference with her contractual relationship with her doctor, Tomczyk attempts to escape the inescapable

(*i.e.*, preemption) by adding a twist, arguing that this Court should consider these state common-law claims as claims for breach of fiduciary duty under ERISA. Appellant's Br. at 19. This Court in *Maciosek* rejected essentially the same argument, 930 F.2d at 540-41, made by the same counsel, who there even relied on the same case, *Cedar Rapids Pediatric Clinic Pension Plan v. Continental Assurance*, 690 F. Supp. 792 (W.D. Ark. 1988). This "ostrich-like" attempt by Tomczyk's counsel to avoid existing authority "is as unprofessional as it is pointless." *Hill v. Norfolk and W. Ry. Co.*, 814 F.2d 1192, 1198 (7th Cir. 1987). We reject this effort to bootstrap state common-law claims onto the ERISA claim. Moreover, because state law breach of contract and tortious interference with contract claims are preempted by ERISA, *see Pilot Life*, 481 U.S. at 57; *Maciosek*, 930 F.2d at 540; *Meyer*, 722 F. Supp. at 553; *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 724 F. Supp. 618, 621 (E.D. Wis. 1989), we affirm their dismissal.[3]

II.

In bringing this appeal, Tomczyk's counsel, Christopher McConville and Marjan Kmiec (both of Kmiec Law Offices), continue a disturbing pattern of litigating claims that repeatedly advance the same frivolous arguments. This case, the most recent in a litany of nonmeritorious

---

[3] Because we affirm the dismissal of both her ERISA and state common-law claims, we need not address Tomczyk's claims for extra-contractual compensatory and punitive damages. Suffice it to note that, although this Circuit had not yet determined the availability of extra-contractual compensatory damages when Tomczyk brought this appeal, we had definitively held that punitive damages are not available under ERISA. *See Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987); *Reilly v. Blue Cross & Blue Shield United of Wisconsin*, 846 F.2d 416, 418 (7th Cir.), *cert. denied*, 488 U.S. 856 (1988). In asserting her punitive damage claim, Tomczyk once again attempted to evade controlling precedent.

ERISA-related cases brought by these attorneys, unfortunately is just one strand in a tangled web of claims manifesting a disregard for the duty of candor that undergirds the judicial system.

In *Smith*, *supra*, the plaintiff, through Kmiec, alleged breach of contract, bad faith breach of contract, breach of fiduciary duty, and intentional infliction of emotional distress, and sought punitive damages. As here, the plaintiff in *Smith* argued that the state law claims should not be preempted by ERISA because of the saving clause. Citing *Pilot Life and Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1986), as well as the District Court decision in *Tomczyk*, *Smith* held that the state law claims and the claim for punitives were preempted by ERISA. Stating that the lawsuit was "patently frivolous," the court imposed Rule 11 sanctions, noting that "the arguments plaintiffs' counsel advances are not good faith reasoning for modification or reversal of the controlling law, but fly in the face of even having read these decisions." 724 F. Supp. at 622-23.

Despite the strong language and clear holding of *Smith*, McConville and Kmiec briefed the *Tomczyk* appeal with only a single reference to it—a comment that "some of these issues herein are currently pending before the Seventh Circuit" and a reservation of the right to amend the brief should *Smith* be decided during the pendency of the *Tomczyk* appeal. Appellant's Br. at 4-5. The brief failed to substantively address the District Court opinion in *Smith*, state its holding, dispute its reasoning, or attempt in any way to distinguish it from the case at hand.

Similarly, Tomczyk's brief failed to adequately address this Court's decision in *Maciosek*. As with *Smith*, the sole reference to *Maciosek* was the comment reserving the right to amend if *Maciosek* were decided during the pendency of Tomczyk's appeal. Unlike *Smith*, *Maciosek* was issued during the pendency. *Maciosek* specifically held that the plaintiffs' claims for breach of contract, tortious interference with a contractual relationship, and inten-

tional infliction of emotional distress were preempted by ERISA, 930 F.2d at 540, and could not be saved by construing them as ERISA claims. *Id.* Rather than acknowledge the unfavorable holding, counsel for Tomczyk chose to misinform this Court. In their reply brief—in which, we note, they were effectively forced to address *Maciosek* following its prominent mention in Blue Cross's brief—Tomczyk's attorneys make the specious argument that "[t]he use of *Maciosek* herein is inapplicable" because

> [t]he *Maciosek* case was not a bad faith case, but instead was treated by the court and parties as a violation of Wisconsin Common Law which prohibited an insurer from recovering mistaken payments unless the payment was caused by a mistake of fact.

Appellant's Reply Br. at 2. This assertion is patently incorrect. The *Maciosek* opinion specifically states that "[t]he state law causes of action . . . obviously are preempted under the Supreme Court's construction of ERISA." 930 F.2d at 540. *Maciosek* is directly applicable to the present case, and its holding obviously precludes Tomczyk's state law claims.

In sanctioning the plaintiff's attorneys in *Smith*, the court admonished that "[c]ounsel cannot ignore settled precedent and bring repeated suits that have no basis in the law." 724 F. Supp. at 624. Similarly, this Court in *Maciosek* affirmed the District Court's imposition of Rule 11 sanctions, chastising counsel for failing to "discuss or distinguish existing law." 930 F.2d at 542. In particular, we criticized Maciosek's counsel for omitting a case from the Eastern District of Wisconsin—namely, *Tomczyk*. *See* 930 F.2d at 541 ("not only did he file this claim after *Tomczyk*, he failed to distinguish it, argue it was wrongly decided, or even acknowledge its existence."). This Court admonished:

> Kmiec argues that the ERISA claims in *Tomczyk* were still pending at the time the Macioseks' claims were filed, so the decision was not a final judgment and no appeal was possible. While that is true, it does

> not explain why Kmiec failed to distinguish a case from the Eastern District of Wisconsin that directly resolved two of the Macioseks' claims. Ignoring precedent from the same jurisdiction is not making a "good faith argument for the extension, modification, or reversal of existing law . . . ." Fed. R. Civ. P. 11. And like it or not, *Tomczyk* was the "existing law" of the district court when these claims were filed, and when Kmiec filed his brief in opposition to the motion to dismiss.

Maciosek, 930 F.2d at 542.

The lessons of *Maciosek* and *Smith* apparently did not take. Tomczyk's brief to this Court failed to adequately discuss or distinguish *Smith* or *Maciosek*, the very cases in which Kmiec and McConville were cited for ignoring existing precedent. Even more egregious, at oral argument, Tomczyk's counsel attempted to explain away the brief's failure to adequately address this Court's decision in *Maciosek* by asserting that it was rendered during the pendency of the *Tomczyk* appeal—the very same argument used (and rejected) before this Court in *Maciosek* as a rationale for failing to address *Tomczyk*!

Moreover, just as the *Maciosek* brief failed to cite the District Court's decision in *Tomczyk*, Tomczyk's brief failed to cite yet another Eastern District of Wisconsin decision, *Meyer v. Employers Health Ins. Co.*, *supra*, despite *Meyer*'s holding that ERISA preempts state-law breach of contract and tortious interference with contract claims and, therefore, its obvious relevance to the present case. When confronted at oral argument with this omission, McConville again mislead this Court, asserting that *Meyer* was inapplicable because it involved a self-insured plan (itself a specious distinction) when in truth, *Meyer*, as here, involved an insured plan.

This tactic of ignoring existing, and potentially dispositive, precedent, as well as the numerous attempts to mislead this Court through bold misrepresentations of fact and law, disserve the parties, opposing counsel, and this

Court. *See Hill*, 814 F.2d at 1198. Under Rule 38, Fed. R. App. P., this Court may award just damages and single or double costs to the appellee if we determine that an appeal is frivolous. We use a two-step process to determine whether sanctions should be issued under this rule: "we must first determine that the appeal is frivolous, and then determine that this is an appropriate case for the imposition of sanctions." *Williams v. United States Postal Serv.*, 873 F.2d 1069, 1075 (7th Cir. 1989); *see Mays v. Chicago Sun-Times*, 865 F.2d 134, 183 (7th Cir. 1989). The rule authorizes sanctions even if the presence of a colorable ground prevented the entire appeal from being adjudged frivolous. *Hill*, 814 F.2d at 1200. We find that this appeal is an appropriate one for sanctions.

Before turning to the specifics of this case, we wish to make clear that it is not our intent to "chill" discussion or to dissuade counsel from bringing credible appeals. Rather, it is our objective to protect the integrity of this system by enforcing attorneys' ethical responsibilities, and to preserve the availability of the federal courts for worthy claims by deterring groundless appeals. *See Hill*, 814 F.2d at 1203; *Mays*, 865 F.2d at 139. We do not seek to make this Court a veritable "minefield" for litigants as they determine whether to pursue appeals. An honest presentation of the case, adherence to the basic technical rules, and a colorable basis in law and fact—as well as a certain amount of common sense—will shield litigants and their attorneys from sanctions. Unfortunately, the attorneys for the appellant in this case transgressed these wide boundaries.

"An appeal is frivolous when the result is obvious or when the appellant's argument is wholly without merit." *Mays*, 865 F.2d at 138 (quoting *Indianapolis Colts v. Mayor of Baltimore*, 775 F.2d 177, 184 (7th Cir. 1985)). Tomczyk's state common-law claims, mimicking others which have consistently been dismissed as preempted by ERISA by this Court and others in this Circuit, obviously fit this description. Likewise, the claim for punitive damages had no colorable basis in the law, was "patently groundless,"

Hill, 814 F.2d at 1200, and therefore frivolous. The appeal of the state common-law and punitive damages claims constituted an "insistence on litigating a question in the face of controlling precedents which removed every colorable basis in law for the litigant's position." *Reid v. United States*, 715 F.2d 1148, 1154 (7th Cir. 1983). Moreover, seeking more than $10 million in punitive damages in this case was "clearly excessive." *Mestayer v. Wisconsin Physicians Serv. Ins. Corp.*, 905 F.2d 1077, 1080-81 (7th Cir. 1990). Counsel for Tomczyk previously have been sanctioned by this Court for seeking such unreasonable damage awards in a case of this nature. *Id.*

We previously have held that misrepresentations of controlling law and disingenuous arguments, "because they postpone resolution of the real issues and cause delay, can be evidence of bad faith under the second part of the Rule 38 analysis." *Williams*, 873 F.2d at 1075 (quoting *Beam v. IPCO Corp.*, 838 F.2d 242, 249 n.5 (7th Cir. 1988)). Such offenses were mainstays of Tomczyk's brief. Many of the cases cited to support Tomczyk's claims were "neither controlling nor relevant." *Morris v. Jenkins*, 819 F.2d 678, 681 (7th Cir. 1987). When the law disfavored Tomczyk's case, it was ignored, glossed over, or misstated. Puffery was proffered as fact. Her attorneys presented the record "in a thoroughly misleading and unprofessional fashion," further demonstrating frivolousness. *Borowski v. DePuy, Inc.*, 850 F.2d 297, 306 (7th Cir. 1988) (citation omitted). The "entire manner in which [this] appeal has been pursued justifies sanctions." *Id.* at 305-06.

Because of the aforementioned conduct before this Court, we have determined that a significant penalty is warranted. Accordingly, we impose sanctions in the amount of $2,000 against Tomczyk's attorneys.[4] Further, Tomczyk's attor-

[4] This Circuit has on several occasions imposed a flat sum award as "damages" under Rule 38 without having evidence of attorneys' fees and other expenses before it. *See, e.g., Cheek v. Doe*, 828 F.2d

(Footnote continued on following page)

neys shall be assessed the costs of this appeal. Blue Cross shall submit to the clerk of this Court within fifteen days of the date of this opinion proper documentation of its expenses in defending this appeal. Counsel for Tomczyk will have an opportunity to contest the amount requested by Blue Cross.

AFFIRMED WITH SANCTIONS.

A true Copy:

Teste:

Clerk of the United States Court of Appeals for the Seventh Circuit

---

[4] *continued*

395, 398 (7th Cir. 1987) ($1500 award); *Hilgeford v. Peoples Bank*, 776 F.2d 176, 179 (7th Cir. 1985) ($500 award), *cert. denied*, 475 U.S. 1123 (1986).

Additionally, as this Court noted in *Hill*, 814 F.2d at 1202, a hearing is not necessarily required by Rule 38. A hearing is required only if there is a contested factual issue. Because no such issue exists in our finding that counsel made objectively groundless legal arguments and factual misstatements, no hearing is warranted in this case.

UNITED STATES COURT OF APPEALS
For the Seventh Circuit
Chicago, Illinois 60604

JUDGMENT—WITH ORAL ARGUMENT

Date: December 30, 1991

BEFORE: Honorable Richard A. Posner, Circuit Judge
Honorable Joel M. Flaum, Circuit Judge
Honorable Michael S. Kanne, Circuit Judge

No. 91-1018

JANE TOMCZYK,

Plaintiff-Appellant

v.

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN,

Defendant-Appellee

Appeal from the United States District Court for the Eastern District of Wisconsin
No. 88 C 690, Judge Robert W. Warren

This cause was heard on the record from the above mentioned district court, and was argued by counsel.

On consideration whereof, IT IS ORDERED AND ADJUDGED by this Court that the judgment of the District Court in this cause appealed from be, and the same is hereby, AFFIRMED, with sanctions Tomczyk's attorneys shall be assessed the costs of this appeal, in accordance with the opinion of this Court filed this date.

[FILED DECEMBER 6, 1990]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

v. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant.

DECISION AND ORDER

I. BACKGROUND

The plaintiff, Jane Tomczyk, brought suit against Blue Cross and Blue Shield United of Wisconsin and First Financial Savings Association for arbitrary and capricious denial of benefits under ERISA, bad faith, breach of contract, tortious interference with contract, and violations of constitutional rights under § 1983.

After the plaintiff stipulated to the dimissal of defendant First Financial Savings Association, defendant Blue Cross and Blue Shield moved for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure. This Court dismissed the plaintiff's state law claims for bad faith, breach of contract and tortious interference with contract and the plaintiff's § 1983 claim. *See Tomczyk v. Blue Cross and Blue Shield United of Wisconsin*, 715 F. Supp. 914 (E.D. Wis. 1989). However, the Court held in abeyance defendant's motion for summary judgment on

the mertits of the lawsuit—*i.e.*, whether plaintiff was entitled to reimbursement of charges incurred for oral surgeries. The Court requested the parties to file supplementary briefs discussing the United States Supreme Court's decision in *Firestone Tire and Rubber v. Burch*, 109 S.Ct. 948 (1989). In *Firestone*, the court held that a denial of benefits challenged under § 1132(a)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine the eligibility for benefits or to construe the terms of the plan. *See id.* at 987.

This Court also held in abeyance defendant's motion to strike plaintiff's demand for a jury trial. In addition, plaintiff has submitted a motion for reconsideration of this Court's dismissal of her state law claims.

II. DEFENDANT'S MOTION FOR SUMMARY JUDGMENT ON PLAINTIFF'S ERISA CLAIM

A. *Summary Judgement Standard*

A motion for summary judgment shall be granted "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law. Fed.R.Civ.P. 56(c). Further, "[i]n reviewing a summary judgment, we must view the record and inferences drawn from it in the light most favorable to the nonmoving party." *Schlifke v. Seafirst Corp.*, 866 F.2d 935, 937 (7th Cir. 1989). However, a scintilla of evidence is not enough to defeat a motion for summary judgment; the nonmovant must go beyond the pleadings by affirmatively demonstrating the existence of a genuine issue of material fact. *Id.* at 938.

B. *Factual Background*

Before this Court addresses the question of whether the defendant properly interpreted the contract, it must address what plaintiff considers to be a dispute of material fact among the parties which prevents summary judgment. Plaintiff and defendant agree on several preliminary facts. However, plaintiff asserts that the parties dispute whether preauthorization review of plaintiff's surgery occurred prior to her surgery.

1. *Undisputed Facts*

First Financial Savings Association, plaintiff's employer, issued a hospital and medical policy of insurance to plaintiff. This policy was in effect at all times relevant to this case.

On September 21, 1987, plaintiff first saw Dr. John A Goeckerman, D.D.S., regarding corrective surgery. After this first consultation, Dr. Goeckerman opined that plaintiff had experienced a developmental skeletal deformity of her maxilla and mandible. Dr. Goeckerman found that plaintiff's deformity would require corrective surgical treatment. Dr. Goeckerman's chosen treatment for plaintiff consisted of two variations of a surgical procedure known as "osteotomy of the temporo mandibular joint."

2. *Disputed Facts*

Defendant asserts that on September 30, 1987, a "Kathy" from Dr. Goeckerman's office telephoned defendant's Advantage Program to get preauthorization of plaintiff's in patient hospital stay for surgery. Defendant states that its employee, Elise McKinch, who took the call, authorized a three-day hospital stay for plaintiff, subject to the terms

and conditions of the contract. Defendant states that Ms. McKinch informed Kathy that defendant's Medical Review Department's preauthorization would be needed for the surgical procedure. Affidavit of Elise McKinch, R.N. Defendant states that the usual follow-up letter from the Advantage Program, confirming the stay was not sent because of the question about coverage. *See Id.*

In her brief in opposition to defendant's motion for summary judgment, plaintiff, through her attorney, asserts that on September 30, 1987, Dr. Goeckerman's office contacted defendant to obtain a preauthorization of plaintiff's surgery. *See* Affidavit of John A. Goeckerman, DDS. Plaintiff further states in her brief that a representative of defendant stated that "plaintiff's insurance was in 'perfect standing' and that her insurance would cover all medical costs regarding the plaintiff's medically necessary surgery, thereby approving said surgical treatments." *See* plaintiff's Brief in Opposition to Defendant's Motion for Summary Judgment, p. 2. Plaintiff, through her attorney, asserts that the Affidavit of Dr. Goeckerman supports the propositin that defendant preauthorized her surgical treatments. Dr. Goeckerman's affidavit states in part:

> That on September 30, 1987, your affiant's office contacted the defendant, Blue Cross, for the purpose of obtaining a preauthorization of the plaintiff's surgery. *That a representative of the defendant, Blue Cross, stated that the plaintiff's insurance had authorized the hospital stay for the intended surgery.*

The affidavit of Dr. Goeckerman clearly states that his office sought preauthorization of the plaintiff's surgery. However, it does not state that defendant authorized such surgery. Rather, it merely states that plaintiff's insurance authorized the hospital stay for plaintiff's surgery.

Because plaintiff presents no evidence in support of her proposition that defendant preauthorized plaintiff's surgery, there is no dispute as to material facts between the parties.

C. *Application of the Firestone Decision to Our Case*

In *Firestone*, the Supreme Court established the standards of review to be used in civil actions to recover benefits under 19 U.S.C. § 1132(a)(1)(B). The *Firestone* court stated:

> Consistent with the established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or a fiduciary discretionary authority to determine the eligibility for benefits or to construe the terms of the plan.

109 S.Ct. at 956.

1. *Whether the De Novo or Arbitrary and Capricious Standard Applies in Our Case*

Defendant asserts that the benefit plan gives it the discretionary authority to construe the terms of the plan and that, therefore, the arbitrary and capricious standard of review is the correct standard. In support of its assertion, defendant notes that under the plan, defendant makes the determination whether an inpatient hospital admission is "medically necessary". The defendant admits that the plan is silent on defendant's authority to construe the terms of the surgery section of the contract. However, defendant asserts that, since the plan has delegated to defendant the authority to determine the con-

troversial and difficult health care concept of medical necessity, the plan must also intend to give discretionary authority to defendant to construe all plan terms.

The Court is not persuaded by defendant's argument. In *Firestone*, the Supreme Court established a gap-filling rule concerning the standard of review to be applied to benefit denials. The Supreme Court held that the parties to a plan could, if they so desired, contract around the gap-filling standard by "agreeing upon a narrower standard of review." *See id.* at 956. Defendant presents no direct evidence that the parties intended to contract around the *de novo* standard for denials of surgery. Instead, defendant merely points to a grant of discretion in another context. However a grant of discretion in one context does not mean that discretionary authority was granted in all contexts. Rather, the fact that the parties chose to explicitly grant discretionary authority in one context and did not do so in another indicates, if anything, that they intended to have discretionary authority in one area and not in the other.

2. *Application of the De Novo Standaard of Review to Defendant's Denial of Benefits*

Section SM-Surgical/Medical Benefits of the insurance contract governs whether plaintiff has coverage. The section provides in part:

> SECTION SM—SURGICAL/MEDICAL BENEFITS
>
> Subject to the limitations, exclusions and conditions of this CONTRACT, a MEMBER is entitled to COVERED SERVICES described in this Section when rendered by PHYSICIANS or PROFESSIONAL OTHER PROVIDERS acting within the scope of

their respective licenses, in the amounts specified in the Schedule of Benefit.

A. *Surgical Services*

1. Surgery

SURGERY, wherever performed, by a PHYSICIAN or PROFESSIONAL OTHER PROVIDER, COVERED SERVICES FOR SURGERY include pre- and post-operative services. Diagnostic x-ray services necessary for the diagnosis of and related to covered surgical procedures are a benefit.

Subsequent surgical procedures (i.e. suture, cast removal), which are normally considered to be an integral part of the prevailing FEE FOR THE INITIAL SURGICAL PROCEDURE, will be considered for payment as a separate service only when performed by a PHYSICIAN other than the operating surgeon.

Surgical services include OUTPATIENT Electroshock Therapy.

2. Special Surgery

a. *Reconstructive Surgery*

SURGERY to restore bodily function or correct deformity resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes; but does not include transsexual SURGERY.

. . .

c. *Oral Surgery*

Oral Surgery limited to the following:

1. Surgical exposure or removal of impacted teeth.

2. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such conditions require a pathological examination.

3. Surgical procedures required to correct accidental injuries to the jaws, cheeks, lips, tongue, roof and floor of the mouth, when such injuries are incurred while a MEMBER is covered under this CONTRACT.

4. Apiccectomy—excision of Apex or tooth root.

5. Excision of exostoses of the jaws and hard palate.

6. Treatment of fractures of facial bones.

7. External incision and drainage of cellulitis.

8. Incision of accessory sinuses, salivary glands or ducts.

9. Reduction of dislocations of, and excision of, the temporomandibular joints.

10. Gingivectomy—Excision of loose gum tissue to eliminate infection.

11. Alveolectomy—The leveling of structures supporting teeth for the purpose of fitting dentures.

12. Frenectomy—Incision of any mid-line fold of tissue between the jaws and lips and between the lower jaw and tongue.

13. Removal of retained (residual) root.

14. Gingival curettage under general anesthesia.

15. Apical curettage.

Section A.1., Surgery, outlines what is included as covered services for surgery. Subsection A.2., Special Surgery, states which types of surgery are covered. The subsection on reconstructive surgery, A.2.a., provides coverage for all corrective surgery except transsexual surgery. The subsection on oral surgery, A.2.c., excludes from oral surgery the surgeries not listed.

Plaintiff asserts that Section SM of the insurance contract is ambiguous because subsections A.2.a. and A.2.c.

are in conflict. Plaintiff states that while she clearly falls within the coverage of the reconstructive surgery subsection, she does not fall within the oral surgery subsection. Plaintiff further asserts that this ambiguity should be construed against the defendant in order to provide coverage for the plaintiff.

It is well settled that ambiguities in an insurance contract are to be construed in favor of the insured. *See Kennedy v. Washington National Insurance Co.*, 136 Wis. 2d 425, 428-29, 401 N.W.2d 842 (1986). In *Caporali v. Washington National Insurance Co.*, 102 Wis. 2d 669, 765-76, 307 N.W.2d 218, 221 (1981) (quoting *Gary Garriguenc v. Love*, 67 Wis. 2d 130, 134-35, 226 N.W.2d 414, 417 (1975)), the Wisconsin Supreme Court restated the standards for construction of terms in insurance policies:

> In the case of an insurance contract, the words are to be construed in accordance with the principle that the test is not what the insurer intended the words to mean but what a reasonable person in the position of an insured would have understood the words to mean. Whatever ambiguity exists in a contract of insurance is resolved in favor of the insured. This is a restatement of the general rule that ambiguous contracts are to be construed most strongly against the maker or drafter. Words or phrases in a contract are ambiguous when they are reasonably or fairly susceptible to more than one construction.

Defendant asserts that Section SM is not ambiguous because it is not reasonably or fairly susceptible to more than one construction. Defendant cites several well-settled rules of contract interpretation which it asserts eliminate any possibility of ambiguity in the contract. Defendant first cites the well-settled principle that a construction of a contract rendering some language useless or surpluage is to be avoided. *See, e.g., Baker v. MeDell Corp.*, 13 Wis.

2d 71, 76-77, 191 N.W.2d 846 (1971). Corpus Juris Secundum outlines this principle of contract construction.

> A construction neutralizing, nullifying, or annulling one provision should not be adopted if the contract can be construed so as to give effect to all of its provisions, and a construction rendering a provision, term, or pare meaningless, superfluous, useless, inexplicable, or nugatory should be avoided.

17A C.J.S. Contracts § 297, p. 125. Because the subsection on reconstructive surgery covers all corrective surgery and since the subsection on oral surgery covers a particular type of corrective surgery, the subsection on oral surgery must be read as a limitation of the reconstructive surgery subsection or be rendered meaningless. If an insured undergoing oral surgery is allowed coverage if he or she falls within either subsection A.2.a. or subsection A.2.c., the insured will always be granted coverage and subsection A.2.c. will become meaningless.

Defendant also cited the well-settled principle that general provisions in contracts yield to specified ones, but where both may be given reasonable effect both are retained. *See, e.g., Johnson v. Green Bay Packers*, 272 Wis. 149, 162, 74 N.W.2d 784, 790-91 (1956) (citing 17 C.J.S., Contracts, § 313, p. 731). In our case, reasonable effect can be given to both subsections only by allowing the oral surgery subsection to be a limitation upon the reconstructive surgery subsection. Otherwise, as stated above, the reconstructive surgery subsection will subsume the oral surgery subsection and make it meaningless.

Finally, defendant cited the principle that a court should choose a contract construction which gives harmonious effect to all the contract's covenants rather than a construction which provides a conflict among some of its covenants. *See, e.g., Bitker & Gerner Co. v. Green Inv. Co.*,

273 Wis. 116, 120, 76 N.W.2d 594, 552 (1956). In our case, only the construction which holds that the oral surgery subsection is a limitation of the reconstructive surgery subsection gives harmonious effect to both subsections. A construction which holds that an insured may have coverage if he or she falls within either subsection creates a conflict between the subsections and makes the oral surgery subsection meaningless.

Read in accordance with settled principles of contract construdtion, Section SM unambiguously limits oral surgery to those listed in the oral surgery subsection. Consequently, this Court finds, under a *de novo* standard of review, that defendant properly denied benefits to plaintiff.

III. PLAINTIFF'S MOTION TO RECONSIDER THE COURT'S DISMISSAL OF HER STATE CAUSES OF ACTION

Plaintiff asks that this Court reconsider its dismissal of her claims of bad faith, breach of contract and tortious interference with contract. Plaintiff states that the Court failed to consider her argument that the Seventh Circuit distinguished between insured and self-insured plans. *See Reilly v. Blue Cross & Blue Shield United of Wis.*, 846 F.2d 416 (1988). Plaintiff argues that because the *Reilly* court held that insured plans, such as the one in our case, are affected by state laws which regulate the insurance industry, claims against such plans are saved from ERISA preemption.

Plaintiff is correct that the *Reilly* court distinguishes insured from self-insured plans. *See id.* at 425. The *Reilly* court held that with self-insured plans, ERISA's "deemer clause" applies and therefore the benefit plan cannot avoid preemption *See id.* Because the benefit plan cannot avoid

preemption, the *Reilly* court stated that it "need not decide whether Wisconsin law concerning punitive damages and bad faith 'regulates insurance.' " *See id.* (citing 29 U.S.C. § 1144(a) (ERISA's "Savings Clause")).

In our case, because the benefit plan in question is not self-insured, this Court was required to determine whether the state law concerning bad faith, breach of contract and tortious interference with contract regulates insurance. This Court applied the test set out by the Supreme Court in *Pilot Life Insurance Co. v. Dedreaux* to determine whether the state law regulates insurance, 481 U.S. 41, 48-49 (1986), and found that it did not.

IV. DEFENDANT'S MOTION TO STRIKE PLAINTIFF'S DEMAND FOR A JURY TRIAL

Because this Court has granted defendant's motions for summary judgment, it is not necessary to address defendant's motion to strike plaintiff's demand for a jury trial.

V. SUMMARY

Under the foregoing reasoning, the Court: (1) GRANTS defendant's motion for summary judgment on plaintiff's ERISA claim; (2) DENIES plaintiff's motion to reconsider the Court's dismissal of her state law claims and (3) DOES NOT CONSIDER defendant's motion to strike plaintiff's demand for a jury trial.

SO ORDERED this 6th day of December, 1990, at Milwaukee, Wisconsin.

/s/ Robert W. Warren
ROBERT W. WARREN
UNITED STATES DISTRICT JUDGE

[FILED MAY 8, 1989]

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

vs. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant.

DECISION AND ORDER

The plaintiff, Jane Tomczyk, brought suit against Blue Cross & Blue Shield United of Wisconsin and First Financial Savings Association for (1) arbitrary and capricious denial of benefits presumably under the Employee Retirement Security Act of 1974 (ERISA), as amended, 29 U.S.C. § 1000 *et seq.*; (2) bad faith; (3) breach of contract; (4) tortious interference with contract; and (5) violation of constitutional rights under section 1983. The plaintiff seeks punitive damages and other extra-contractual damages.

The plaintiff stipulated to the dismissal of defendant First Financial Savings Association. Defendant Blue Cross & Blue Shield United of Wisconsin now moves for summary judgment pursuant to Rule 56 of the Federal Rules of Civil Procedure, on the grounds that there is no controversy with respect to any fact necessary to determine the correctness of defendant's decision denying plaintiff's claim for benefits.

Alternatively, defendant moves the Court for an order, pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure, dismissing plaintiff's claims for bad faith, breach of contract, tortious interference with contract, punitive and other extra-contractual damages on the grounds that these state law causes of action are pre-empted by the provisions of ERISA; for an order dismissing plaintiff's section 1983 claim on the ground that no state action is alleged; and for an order dismissing plaintiff's demand for trial by jury.

The Court dismisses the plaintiff's state law claims for bad faith, breach of contract, tortious interference with contract, and punitive and other extra-contractual damages. The Court also dismisses the plaintiff's section 1983 claim. The Court holds in abeyance the motion for summary judgment. In light of *Firestone Tire & Rubber Co. v. Bruch*, Case No. 87-1054 (U.S. Feb. 21, 1989) (a denial of benefits challenged under section 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan), the Court requests the parties to supplement their briefs with a discussion of this recent Supreme Court case. The Court further holds in abeyance the defendant's motion for a jury trial.

I.

Blue Cross issued a policy of group health insurance to the Wisconsin League of Financial Institutions, Ltd. (Savings League). At all times relevant to this action, Jane Tomczyk was employed by First Financial Savings Association. Through its membership in the Savings League, First Financial Savings Association was able to procure

insurance for its employees under the Savings League's program with Blue Cross. Jane Tomczyk was a subscriber under this program of insurance.

II.

In ERISA, Congress set out to:

> "protect . . . participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts." § 2, as set forth in 29 U.S.C. § 1001(b).

ERISA comprehensively regulates, among other things, employee welfare benefit plans that, "through the purchase of insurance or otherwise" provide medical, surgical, or hospital care, or benefits in the event of sickness, accident, disability, or death. § 3(1), 29 U.S.C. § 1002(1).

Congress capped off the massive undertaking of ERISA with three provisions relating to the preemptive effect of federal legislation:

> "Except as provided in subsection (b) of this section [the saving clause], the provisions of this subchapter and subchapter III of this chapter shall supersede any and all state laws insofar as they may now or hereafter relate to any employee benefit plan. . . ." § 514(a), as set forth in 29 U.S.C. § 1144(b)(2)(A) (saving clause).
>
> "Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment com-

> pany or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies." § 54(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B) (deemer clause).

To summarize the pure mechanics of the provisions quoted above: If a state law 'relate[s] to . . . employee benefit plan[s]," it is pre-empted. § 514a. The saving clause excepts from the pre-emption clause laws that "regulat[e] insurance." § 514(b)(2)(A). The deemer clause makes clear that a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company. § 514(b)(2)(B).

"[T]he question whether a certain state action is preempted by federal law is one of congressional intent. ' "The purpose of Congress is the ultimate touchstone." ' " *Allis-Chalmers Corp. v. Lueck*, 471 U.S. 202, 208 (1985), *quoting Malone v. White Motor Corp.*, 435 U.S. 497, 504 (1978), *quoting Retail Clerks v. Schermerhorn*, 375 U.S. 96, 103 (1963). We have observed in the past that the express pre-emption provisions of ERISA are deliberately expansive, and designed to "establish pension plan regulation as exclusively a federal concern." *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). As we explained in *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983):

> "The bill that became ERISA originally contained a limited pre-emption clause, applicable only to state laws relating to the specific subjects covered by ERISA. The Conference Committee rejected those provisions in favor of the present language, and indicated that section's pre-emptive scope was as broad as its language. See H.R. Conf. Rep. No. 93-1280, p. 383 (1974); S.Conf. Rep. No. 93-1090, p. 383 (1974)."

> The House and Senate sponsors emphasized both the breadth and importance of the pre-emption provisions. Representative Dent described the "reservation to Federal authority the sole power to regulate the field of employee benefit plans" as ERISA's "crowning achievement." 120 Cong. Rec. 29197 (1974). Senator Williams said:
>
> > "It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of the employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force and effect of law." *Id.*, at 29933.
>
> See also *Shaw v. Delta Air Lines, Inc.*, *supra*, at 99-100, n.20 (describing remarks of Sen. Javits).

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 44-46 (1986).

The state law causes of action in the plaintiff's complaint relate to an employee benefit plan and therefore fall under ERISA's express preemption clause, section 514(a). A law relates to a benefit plan if it has a connection with or reference to such a plan. *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. at 47. The pre-emption clause is not limited to "state laws specifically designed to affect employee benefit plans." *Pilot Life*, 481 U.S. at 48, *citing Shaw v. Delta Air Lines*, 463 U.S. 85, 98 (1983).

Unless these causes of action fall under an exception to section 514(a), therefore, they are expressly pre-empted.

> In *Metropolitan Life*, we were guided by several considerations in determining whether a state law falls under the saving clause. First, we took what

> guidance was available from a "common sense view" of the language of the saving clause itself. 471 U.S., at 740. Second, we made use of the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. § 1011 *et seq.*, in interpreting the saving clause. Three criteria have been used to determine whether a practice falls under the "business of insurance" for purposes of the McCarran-Ferguson Act:
>
> "*[F]irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, *cert. denied*, the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (emphasis in original).

Pilot Life Insurance Co. v. Dedreaux, 481 U.S. at 48-49.

The Supreme Court determined that the Mississippi law of bad faith does not "regulate insurance" under a common sense view. *Pilot Life*, 481 U.S. at 50. "Mississippi's law of bad faith, even if associated with the insurance industry, has developed from general principles of tort and contract law available in any Mississippi breach of contract case." *Pilot Life*, 481 U.S. at 51. The Wisconsin law of bad faith is also firmly rooted in general principles of tort and contract law. As the Wisconsin Supreme Court has noted in discussing bad faith, "Every contract imposes upon each party a duty of good faith and fair dealing in its performance and enforcement." *Anderson v. Continental Insurance*, 85 Wis.2d 675, 689, 271 N.W.2d 368, 375 (1978). *See also Rust v. Blue Cross & Blue Shield*, No. 87-C-0751 (E.D. Wis. Sept. 21, 1988) (J. Warren, presiding).

The Supreme Court also held that the Mississippi law of bad faith does not regulate insurance within the mean-

ing of the McCarran-Ferguson Act. *Pilot Life*, 481 U.S. at 50. Likewise, the Wisconsin law of bad faith does not regulate insurance within the meaning of the Act. It does not effect a spreading of policyholder risk; it does not define the terms of the relationship between the insurer and the insured, it only declares that a breach of contract may in certain circumstances allow the policyholder to obtain punitive damages; and, finally, it is not limited to entities in the insurance industry.

The Supreme Court finally held that it was the clear expression of congressional intent that ERISA's civil enforcement scheme be exclusive. *Pilot Life*, 481 U.S. at 57.

Based on the *Pilot Life* analysis, the Court concludes that the tort of bad faith in Wisconsin is pre-empted and not saved by ERISA. The plaintiff's other state law causes of action, breach of contract and tortious interference with contract also are pre-empted by ERISA. *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1986) (common law contract and tort claims are pre-empted by ERISA under *Pilot Life* and are not saved). The Court therefore DISMISSES the plaintiff's bad faith, breach of contract, and tortious interference with contract claims.

III.

Because ERISA pre-empts state law causes of action, the plaintiff's only viable cause of action is under ERISA, which provides for the following recovery:

> A civil action may be brought:
>
> (1) by a participant or beneficiary—
>
> (A) for the relief provided for in subsection (c) of this section or

> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;
>
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 409 [§29 U.S.C. § 1109];
>
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this title or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this title or the terms of the plan.

29 U.S.C. § 1132.

The Supreme Court has stated that "there is a stark absence—in the statute itself and in its legislative history—of any reference to an intention to authorize the recovery of extracontractual damages." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1984). The Court therefore held that plaintiff did not have a cause of action for extracontractual damages caused by improper or untimely processing of benefit claims under 29 U.S.C. § 1132(a)(2). In addition, the Court of Appeals for the Seventh Circuit has held that plaintiff did not have a cause of action for punitive damages under 29 U.S.C. § 1132(a)(3). *Klinhans v. Lisle Sav. Profit Sharing Trust*, 810 F.2d 618, 636-627 (7th Cir. 1987). Based on these cases, the Court DISMISSES the plaintiff's claims for extracontractual damages.

IV.

An action under section 1983 is available only if "state action" is present. *Ezpeleta v. Sisters of Merch Health Corp.*, 800 F.2d 119, 133 (7th Cir. 1986). The plaintiff purports to satisf the state action requirement by asserting

that "Blue Cross is licensed and extensively regulatd by the Insurance Commissioner pursuant to state law, under the Wisconsin Administrative Code, Ins. 1.01-20.01, Wis. Adm. Code." "It is settled, however, that the mere existence of detailed regulation of a private entity does not make every act, or even every regulated act, of the private firm, the action of the State." *Cohen v. Illinois Institute of Technology*, 524 F.2d 818, 826 (7th Cir. 1975). "Unless it is alleged that the regulatory agency has encouraged the practice in question, or at least given its affirmative approval to the practice, the fact that a business or institution is subject to regulation is not of decisive importance." *Id.* The defendant's decision to deny benefits is "a purely private one", notwithstanding that it is licensed and regulated by the state. *Koller v. Aetna Life Insurance Co.*, Case No. 87-C-903, slip op. at 2 (E.D. Wis., Mar. 1, 1988) (J. Stadtmueller, presiding). Because the plaintiff has failed to allege facts which would support her allegation that Blue Cross acted under color of state law in denying her claims, the Court DISMISSES the plaintiff's section 1983 claim.

V.

The Court has approved the parties' stipulation for an extension of discovery to a date following the Court's resolution of the pending summary judgment motion. The Court therefore has taken the pretrial conference scheduled for May 9, 1989 off the Court's calendar. The conference will be rescheduled, if appropriate, in the order resolving the motion for summary judgment.

SO ORDERED this 8th day of May, 1989, at Milwaukee, Wisconsin.

/s/ Robert W. Warren
ROBERT W. WARREN
UNITED STATES DISTRICT JUDGE

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN
Case No.: 91-1018

JANE TOMCZYK,

Plaintiff-Appellant,

v.

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN,
THE HONORALE ROBERT W. WARREN, PRESIDING, OF
DECISIONS AND ORDERS GRANTING SUMMARY
JUDGMENT IN FAVOR OF THE DEFENDANT-APPELLEE.

APPELLANT'S BRIEF AND APPENDIX

KMIEC LAW OFFICES
3741 West National Avenue
Milwaukee, WI 53215
(414) 649-9790

* * * * *

[p. 19] considered state law claims, are in fact, now federal law claims. To this end, the Supreme Court in **Pilot**

Life acknowledged the development of a body of federal common law stemming from the regulatory scheme of ERISA. **107 S.Ct. at 1557-1558.**

Following this reasoning, the **Cedar Rapids Pediatric Clinic Pension Plan v. Continental Ins. Co., 690 F. Supp. 792, 795 (W.D. Ark. 1988)** court stated that the plaintiff's allegations as to common law claims based in breach of contract and negligence, state a claim under ERISA for breach of fiduciary duty. (See generally, **29 U.S.C. Sec. 1104(a)).** Although state common law claims are preempted under ERISA, and will be dismissed as state claims based upon **29 U.S.C. 1104(a)** the **Cedar Rapids** court however held it will "instead construe the plaintiff's common law allegations as descriptive claims that can be admittedly brought under ERISA." **690 F. Supp. at 795-796.**

As such, Jane Tomczyk's claim for breach of contract and tortious interference with contract is simply considered as a claim for breach of fiduciary duty under ERISA, **29 U.S.C. Sec. 1104(a).** This reasoning directly comports with the basic purpose or ERISA, to protect the rights and benefits of employees through a broad interpretation of federal and state remedies.

Without dispute, recoverability of extra-contractual damages in ERISA actions remain an unsettled area of law. **Vogel v. Independent Federal Savings Bank, 692 F. Supp. 587, 594 (D. Md. 198).** The **Vogel** court stated, following the Supreme Court ruling in **Massachusetts Mut'l Life Ins. Co. v. Russell, 105 S.Ct.**

* * * * *

UNITED STATES DISTRICT COURT
FOR THE SEVENTH CIRCUIT
Case No.: 91-1018

JANE TOMCZYK,

Plaintiff-Appellant,

v.

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant-Appellee.

APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN,
THE HONORALE ROBERT W. WARREN, PRESIDING, OF
DECISIONS AND ORDER GRANTING SUMMARY
JUDGMENT IN FAVOR OF THE DEFENDANT-APPELLEE.

APPELLANT'S REPLY BRIEF

KMIEC LAW OFFICES
3741 West National Avenue
Milwaukee, WI 53215
(414) 649-9790

* * * * *

[p. 3] plan, they are directly affected by state laws that regulate insurance. **105 S.Ct. at 2395.** Blue Cross refuses

to address this analysis and makes the quantum leap that since this is an ERISA governed case, Wisconsin state law claims for bad faith and punitive damages are preempted. This quantum leap approach by Blue Cross simply is insufficient for Jane Tomczyk to address. Therefore, Jane Tomczyk respectfully requests this court to reverse the district court's ruling in preempting her state law claims for bad faith and punitive damages.

C. CONGRESS AND THE U.S. SUPREME COURT HAVE PROVIDED FOR THE DEVELOPMENT OF FEDERAL COMMON LAW CLAIMS AS THEY RELATE TO ERISA.

The Supreme Court stated in **Pilot Life Ins. Co. v. Dedeaux, 107 S.Ct. at 1557-1558,** that " "it is also intended that a body of federal substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans". The expectations that a federal common law of rights and obligations under ERISA regulate plans would develop, indeed, the entire comparison of **ERISA Sec. 502(A)** to **Sec. 301 of the LMRA,** would make little sense if the remedies available to ERISA participants and beneficiaries under **Sec. 502(a)** could be supplemented or supplanted by varying state laws."

> " "The legislative history demonstrates that Congress intended federal courts to develop federal common law in fashioning additional 'appropriate equitable relief.' In presenting the conference report to the full Senate, for example, Senator Javits, ranking minority member of Senate Committee on Labor and Public Welfare and one of the two principle Senate sponsors of ERISA, stated that "it is also intended that a body of federal substantive law will be developed by the courts [p. 4] to deal with issues involving

> rights and obligations under private welfare and pension plans." (Citation omitted). Senator Williams, the Committee's Chairman and the Act's other principle senator sponsor summarily emphasizes that suits involving beneficiary rights "will be regarded as arising under the laws of the United States, in similar fashion to those brought under **Sec. 301 of the Labor Management Relations Act.**" (Citation omitted). Sec. 301, of course, "authorizes federal courts to fashion a body of federal law" in contexts of collective bargaining agreements, to be derived by "looking at the policy of the legislation fashioning a remedy that will effectuate that policy." (Citation omitted). **Massachusetts Mut'l Life Ins. Co. v. Russell, 105 S.Ct. 3085, 3097-3098 (1985).**

Along with its ruling in **Pilot Life** and **Mackey v. Lanier Collections Agency & Service, 108 S.Ct. 2182, 2187 (1988),** the Supreme Court has recognized that the federal courts are requested to develop an area of federal common law under **Sec. 503(a) of ERISA.** This is the sole intent of Jane Tomczyk in pursuing an appeal for her claims for breach of contract, tortious interference with contract and extra-contractual damages.

Furthermore, this is not a claim for extra-contractual benefits under **29 U.S.C. Sec. 1132(a)(2).** These damages are precluded under **29 U.S.C. Sec. 1132(a)(2)** pursuant to **Massachusetts Mut'l Life Inc. Co. v. Russell, 105 S.Ct. 3085, 3094-3095 (1985).** A claim for extra-contractual damages, however, has not been precluded under **29 U.S.C. Sec. 1132(a)(1)(b) and (a)(3). 105 S.Ct. at** 3094-3095. It was Justice Brennan in **Russell** that stated, "thus while it may be that courts generally may not find implied private remedies in ERISA, the court's remarks have little bearing on how courts are

* * * * *

[DATED NOVEMBER 29, 1988]

UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

v. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD,
et al.,

Defendant.

AFFIDAVIT OF JOHN A. GOECKERMANN, D.D.S.

STATE OF WISCONSIN
MILWAUKEE COUNTY—ss

JOHN A. GOECKERMAN, D.D.S., being first duly sworn, on oath deposes and states that:

1. Your affiant is the treating physician of the plaintiff herein. That your affiant makes this affidavit on personal knowledge and in support of the plaintiff's brief in opposition to the defendants motion summary judgment.

2. That on September 30, 1987, your affiant's office contacted the defendant, Blue Cross, for the purpose of obtaining a preauthorization of the plaintiff's surgery. That a representative of the defendant, Blue Cross, stated that the plaintiff's insurance had authorized the hospital stay for the intended surgery.

3. That attached hereto and marked as Exhibit A is a true and correct copy of a letter your affiant sent to the defendant, Blue Cross. Said letter contains your affiant's diagnosis that the plaintiff required surgical care and that failure to have the necessary surgery would result in a malocclusion making it very difficult for the plaintiff to maintain a normal diet due to her inability to properly chew food for appropriate digestion. Moreover, said Exhibit A included the surgical fee and a cost breakdown of the treatment that the plaintiff would receive.

4. That on June 8, 1988 or June 9, 1988, your affiant received a telephone call from a representative of Blue Cross advising your affiant that the review board had reviewed Ms. Tomczyk's claim and decided that Blue Cross would not pay for the surgery because it was not a covered benefit. Your affiant asked the representative at that time if it was specifically stated in the policy that it was not a covered benefit. The representative of Blue Cross stated, "no" that they (Blue Cross) were just not paying the bill.

Dated this 29 day of November, 1988.

/s/ John A. Goeckerman, D.D.S.

[Notarization omitted in printing]

EXHIBIT A

(Letterhead Of)
DR. JOHN A. GOECKERMANN
4200 South 27th Street, Suite 102
Milwaukee, Wisconsin 53221

October 7, 1981

Blue Cross Blue Shield
P. O. Box 2141
Milwaukee, Wisconsin 53201

Re: Jane E. Tomczyk
0A0396647973

Gentlemen:

This letter is sent as a request for prior determination of benefits for Ms. Jane Tomczyk to undergo corrective surgery of a developmental skeletal deformity of her maxilla and mandible. Ms. Tomczyk presented to my office on 9/21/87 and was referred by Dr. Robert Schlamer for evaluation of the skeletal component of her maxillary and mandibular discrepancy and recommendation of a surgical treatment plan to correct this deformity. Ms. Tomczyk's chief complaint at the time of initial examination was difficulty with mastication and speech function as well as generalized maxillomandibular function.

Clinical examination shows vertical maxillary hyperplasia with mandibular retrognathia. There is misalignment of the posterior segments of the maxilla with those of the mandible and transverse maxillary deficiency is apparent. The discrepancy between maxillary and mandibular segmental alignment results in a malocclusion that makes mastication and assimilation of a normal diet very difficult.

Radiographic assessment shows vertical maxillary excess combined with mandibular retrognathia. The anteropos-

terior deficiency of the mandible is significant and correction of the discrepancy in this plane cannot be accomplished entirely with a maxillary osteotomy intrusion and autorotation of the mandible.

The surgical procedure required to correct Ms. Tomczyk's skeletal maxillary and mandibular deformity is a LeFort I segmental osteotomy intrusion and expansion of the maxilla combined with a sagittal split ramus osteotomy advancement of the mandible. The surgical fee for the LeFort I osteotomy with multiple sections is $3,400.00 and the surgical fee for the mandibular sagittal osteotomy is $2,200.00. In addition, due to the nature and complexity of the surgery a surgical assistant is required and his fee is typically twenty-five percent of the surgery fee. The procedure will required three to four days of hospitalization.

Please give consideration to this request for prior determination of benefits for Ms. Jane Tomczyk to undergo the intended corrective surgery of her maxilla and mandible. The purpose of this surgery is to provide her with a significant functional improvement so that she might be able to consume a more normal diet and function in a manner consistent with normal occlusion. If I may be of further assistance in clarification of the nature or purpose of the intended surgery, please feel free to contact me.

Sincerely,

John A. Goeckerman, D.D.S., M.S.

JAG/kal

Enclosure

Blue Cross & Blue Shield
United of Wisconsin

401 W Michigan St.
Milwaukee, WI 53201

JANE E TOMCZYK
3944 EAST IONA TERRACE
CUDAHY WI 53110

If you have any questions, please have your identification Number and Claim Number available and call or write:
LOCAL: 226-5163
IN-WIS: 1-800-242-9889
OUT-WIS: 1-800-558-7179 BOX# 2141

EXPLANATION OF BENEFITS

STATEMENT DATE 11/13/87

IDENTIFICATION NO.	CONTROL NUMBER
0A039-664-7973	0000106490053

SEE BACK OF FORM FOR EXPLANATION OF COLUMNS

PATIENT'S NAME / CLAIM NUMBER 1	PROVIDER'S NAME / DESCRIPTION OF SERVICES 2	DATES OF SERVICE 3	AMOUNT CHARGED 4	UCR DIFFERENCE 5	YOUR PORTION 6	REASON 7	AMOUNT PAID
JANE E TOMCZYK	J A BOECKERMAN DDS	10/21/87					
1187306-0231100	ORAL SURGERY PROCEDURE	10/21/87	40.00	.00	40.00	0	.00*
	ORAL SURGERY PROCEDURE	10/27/87	360.00	.00	360.00	0	.00*
	ORAL SURGERY PROCEDURE	10/27/87	90.00	.00	90.00	0	.00*
	TOTALS ----------		494.00	.00	494.00	.01	.00
1-WE ARE HAPPY TO BE OF SERVICE TO YOU.							

226-9915
+ lic 8-7
9-30-87

Exhibit "A"

*Payment of this claim has been made to provider

FDSN 926807242 REFERENCE NO: 926808039664797 3 TOTAL 494.00 .00 494.00 .00

BEST AVAILABLE COPY

EXHIBIT C

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

JANE TOMCZYK,

Plaintiff,

vs. Case No. 88-C-690

BLUE CROSS & BLUE SHIELD
UNITED OF WISCONSIN,

Defendant.

AFFIDAVIT OF ELISE McKINCH, R.N., B.S.

STATE OF WISCONSIN
COUNTY OF MILWAUKEE—ss

Elise McKinch, R.N., B.S. being first duly sworn, does hereby depose and state that:

1. She is employed by Blue Cross & Blue Shield United of Wisconsin (Blue Cross), 401 West Michigan Street, Milwaukee, Wisconsin, in the position of Managed Care Specialist. She has been so employed since May of 1987.

2. In her capacity as Managed Care Specialist she reviews inpatient hospital admissions and authorizes lengths of stay in connection with Blue Cross' managed care program, also known as the Advantage Program

3. In the course of performing these duties, she electronically documents all information relevant to the inpatient authorizations. She enters into a computer all infor-

mation on the patient's membership, eligibility, the request for admission, and the necessity of a second opinion. She also enters summaries of her conversations with the patient and the provider. By retrieving this electronically stored information, she was able to reconstruct the conversation described below.

4. On September 30, 1987, a "Kathy" from Dr. John Goeckermann's office telephoned Blue Cross' Advantage Program to get a preauthorization of an inpatient hospital admission for Blue Cross subscriber Jane Tomczyk. I took this telephone call. The caller informed me that the surgery necessitating the stay was a Lefort I osteotomy and a Sagittla Split Ramus osteotomy. Because jaw and mouth surgery is only covered in limited instances under Blue Cross contracts, I knew that coverage of the proposed surgical procedures was questionable. I instructed the caller that it would be advisable to get verification of coverage from Blue Cross' Medical Review department. I informed the caller that I would authorize a three day inpatient hospital stay. I informed the caller that the authorization related to the patient's need to have the procedures done as an inpatient and was not an authorization of coverage. The caller said that she would send a request to Blue Cross' Medical Review department for a preauthorization of coverage for the surgical procedures.

5. Because I had determined, and informed the caller, that medical review was necessary, I did not send Dr. Goeckermann's office the customary letter of confirmation of the inpatient admission preauthorization.

/s/ Elise M. McKinch
Elise McKinch
Affiant

[Notarization omitted in printing]

THE MILWAUKEE SENTINEL—January 3, 1992

Federal court penalizes law firm $2,000 for frivolous appeal

By TANNETTE JOHNSON-ELIE
Sentinel staff writer

A Milwaukee law firm has been ordered to pay $2,000 in sanctions by the 7th U.S. Court of Appeals for bringing a frivolous appeal.

In its decision returned Thursday, the 7th Circuit ruled that there was no reasonable basis for an appeal brought by attorneys Marjan Kmiec and Christopher McConville of the Kmiec Law Offices.

The court imposed Rule 38 sanctions, which authorize penalties for frivolous appeals.

The case involved a dispute over health care benefits involving Jane Tomczyk, of Cudahy, and Blue Cross & Blue Shield United of Wisconsin.

Tomczyk sued Blue Cross in Federal Court in 1987, charging that the insurer acted in bad faith by denying her reimbursement of $8,250 in surgical and hospital fees.

The suit alleged that Blue Cross violated the Employee Retirement Income Security Act, a federal law that regulates insurance and other employee benefits.

Tomczyk, who was employed by First Financial Savings Association, underwent oral surgery in 1987 and filed a claim with Blue Cross, which denied it.

Her suit was dismissed by Federal Judge Robert W. Warren, who ruled that the surgery was not covered under her health insurance plan with Blue Cross.

Tomczyk appealed the decision, and her attorneys have been ordered to pay the expenses of Blue Cross in defending the appeal.

The 7th Circuit issues a scathing criticism of Kmiec and McConville, charging that cases they cited to support Tomczyk's claims were irrelevant.

"When the law disfavored Tomczyk's case, it was ignored, glossed over or misstated," the 7th Circuit wrote. "Puffery was proffered as fact.

"Her attorneys represented the record in a thoroughly misleading and unprofessional fashion, further demonstrating frivolousness."

The appeals court rejected McConville's argument that Blue Cross authorized Tomczyk's hospital stay, which entitled her to coverage of medical expenses.

McConville, however, defended his position when contacted Thursday.

"The doctor received the OK by Blue Cross to go ahead and perform the surgery," McConville said. "I still think it's a valid argument."

McConville said the case has been damaging to Tomczyk, who filed for bankruptcy.

"The poor lady can't afford to pay the medical bills that Blue Cross was supposed to pay," McConville said.

Laurel Barnes, assistant general counsel for Blue Cross, said she was not surprised by the appeals court decision.

"I expected it to come down the way it did," Barnes said. "This is good for insurers and people covered by employee benefit plans because when you figure punitive damages into the health care cost equation, you inject unpredictability into health care and it's expensive enough."

McConville said the decision sends a negative message to consumers. "It says you don't have rights under the federal law."